STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056023	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Villa Care Center	12029 Avalon Blvd Los Angeles, CA 90061

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on observation, interview, and record review, the facility failed to ensure two of eight sampled residents (Resident 75 and 42) were accommodated with their requests for a blanket and clean bed linens, and a walker and/or wheelchair. These deficient practices had the potential to violate Residents 75 and 42's rights. Findings: a. During a review of Resident 75's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 75 was admitted to the facility on [DATE]. Resident 75's diagnoses included dysphagia (difficulty swallowing), muscle weakness (loss of muscle strength), and hypertension ([HTN]- high blood pressure. During a review of Resident 75's Minimum Data Set ([MDS]- a resident assessment tool), dated 1/8/2025, the MDS indicated Resident 75's cognitive (the ability to think and process information) skills for daily decisions making was intact. The MDS indicated Resident 75 was independent with eating, toileting hygiene, and upper body dressing. The MDS indicated Resident 75 required moderate (helper does less than half the effort) assistance from staff for showering/bathing. During a concurrent observation and interview on 1/28/2025 at 3:45 p.m., with Resident 75, in Resident 75's room, Resident 75 stated during the night he was feeling cold and unable to sleep. Resident 75 stated he needed an extra blanket. Resident 75 stated his bed linens were not clean and needed to be changed. Resident 75 stated he requested extra bed linens. Resident 75 stated he asked Certified Nursing Assistant (CNA 3) for an extra blanket and requested his bed linen be changed. Resident 75 stated CNA 3 refused to change his bed linen and refused to give him an extra blanket and bed linen. Resident 75 stated he felt disrespected and upset. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/28/2025 at 4:05 p.m., with CNA 3, CNA 3 stated Resident 75 requested an extra blanket and extra bed linen because he (Resident 75) felt cold during the night. CNA 3 stated she did not provide Resident 75 an extra blanket because it was not nighttime yet, and she told Resident 75 to request an extra blanket from another CNA on the nighttime shift. CNA 3 stated she did not change Resident 75's bed linen because the resident requested two bed linens and the facility was to provide one bed linen a day. CNA 3 stated it was her responsibility to provide Resident 75 with care and assistance when requested. CNA 3 stated it was Resident 75's right to ask for assistance and care when needed. CNA 3 stated she should have provided Resident 75 with assistance and care right away when Resident 75 asked. CNA 3 stated it was Resident 75's right to be treated with respect and dignity. b. During a review of Resident 42's Face Sheet, the Face Sheet indicated Resident 42 Resident 42 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 42's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), muscle weakness, and dysphagia. During a review of Resident 42's MDS, dated [DATE], the MDS indicated Resident 42's cognitive skills for daily living was moderately impaired. The MDS indicated Resident 42 required moderate assistance from staff for ADLs. During an observation on 1/29/2025 at 2:25 p.m., in the hallway, observed Resident 42's room door closed. The call light was on. During an observation on 1/29/2025 at 2:35 p.m., in the hallway, observed CNA 3 walk by Resident 42's room and open the door without entering the room. CNA 3 turned off the call light then closed the door and walked way. During a concurrent observation and interview on 1/29/2025 at 2:43 p.m., with Resident 42, in Resident 42's room, observed Resident 42 lying in bed, looking outside the window. There was no wheelchair and/or walker observed in the room. Resident 42 stated she wanted to go outside the patio and needed a wheelchair and/or walker. Resident 42 stated she used to have a wheelchair and a walker in her room. During an interview on 1/29/2025 at 3:03 p.m., with CNA 3, CNA 3 stated she observed that Resident 42's call light was on and went to check the resident. CNA 3 stated she observed Resident 42 lying in bed and thought that Resident 42 accidently pressed the call light. CNA 3 stated she should have walked into Resident 42's room and attended to Resident 42's needs. CNA 3 stated she was not aware that Resident 42 wanted to go to the outside patio. CNA 3 stated she was not aware that Resident 42 needed a wheelchair and /or walker. CNA 3 stated she was in a hurry. CNA 3 stated it was important to treat Resident 42 with respect and attend to her needs appropriately. During an interview on 1/29/2025 at 3:15 p.m., with the Director of Staff Development (DSD), the DSD stated CNAs should answer resident's call lights appropriately and provide care and assistance timely. The DSD stated it was the resident's right to be treated with respect and dignity. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled Resident Rights, revised 8/2009, the P&P indicated employees shall treat all residents with kindness, respect, and dignity. During a review of the facility's P&P titled Answering the Call Light, revised 10/2010, the P&P indicated staff would respond to the resident's request and needs. The P&P indicated: a) Answer the resident's call as soon as possible. b) Turn off the call light. c) Identify yourself and call the resident by her/his name. d) Listen to the resident's request. e) Do what the resident asked of you. During a review of the facility's Job Description- Certified Nursing Assistant (CNA), undated, the job description indicated the CNA would perform resident care and services essential to caring for personal needs and comfort of residents. The P&P indicated CNA would treat all residents fairly, and with kindness, dignity, and respect.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on interview and record review, the facility failed to obtain informed consent (a process during which residents or caregivers are educated regarding the potential risks and benefits of medication therapy) from the resident or their responsible party (a person delegated to make medical decisions for the resident in the event they are unable to do so) prior to treatment of Cymbalta (a medication used to treat mental illness) for one of five residents sampled for unnecessary medications (Resident 1). The deficient practice of failing to obtain informed consent prior to initiating treatment with psychotropic (medications that affect brain activities associated with mental processed and behavior) medications could have prevented Resident 1 from exercising his right to decline treatment with Cymbalta. This increased the risk that Resident 1 could have experienced adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to Cymbalta leading to impairment or decline in his mental or physical condition or functional or psychosocial status. Findings: During a review of Resident 1's Admission Record (a record containing diagnostic and demographic resident information), dated 1/29/2025, the admission record indicated the resident was admitted to the facility on [DATE] with diagnoses including schizophrenia (a mental illness characterized by hearing or seeing things that are not there) and major depressive disorder (MDD - a mental illness characterized by depressed mood, lack of interest in activities, poor appetite, and/or trouble sleeping). During a review of Resident 1's Psychiatric Note (a medical progress assessment written by a psychiatric care provider) dated 1/2/2025, the psychiatric note indicated the resident had the capacity to understand and make decisions unless exacerbation of paranoid thoughts. During a review of Resident 1's Order Summary Report (a summary of all current physician orders), dated 1/29/2025, the order summary report indicated, on 7/1/2023, Resident 1's attending physician prescribed Cymbalta 30 milligrams (mg - a unit of measure for mass) by mouth once daily for polyneuropathy unspecified (nerve-related pain). During a review of Resident 1's available informed consent documentation and clinical record indicated, there was no documentation that Resident 1 or any responsible party received education regarding the risks and benefits of Cymbalta prior to its initiation on 7/2/2023. During an interview on 1/29/2025 at 12:30 p.m. with the Director of Nursing (DON), the DON stated that the facility failed to obtain informed consent related to the informed consent for Cymbalta. The DON stated it was missing likely because his staff did not know that it was needed even if it was not being used for behavioral management. The DON stated even though this medication was being used to treat nerve pain for Resident 1, it was still a psychotropic medication which affected the brain, and needed an informed consent before being initiated. The DON stated there was a risk that the resident or responsible party would not be able to exercise their right to opt out of treatment with Cymbalta if the informed consent was not done. The DON stated this increased the risk that Resident 1 could have experienced adverse effects related to treatment with Cymbalta. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's undated policy and procedure (P&P) titled, Informed Consent, the P&P indicated The facility shall ensure the resident's rights are maintained . among these rights under this sections are the right to: .consent to or to refuse any treatment . The use of psychotropic drugs . shall be initiated when the facility is able to verify that the resident or resident representative has given informed consent .

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on observation, interview, and record review, the facility failed to ensure the call light (a device that residents use to request assistance from staff) was within reach for one of eight sampled residents (Resident 42). This deficient practice had the potential to negatively impact Resident 42's psychosocial well-being and/or result in delayed provision of care and services. Findings: During an observation on 1/27/2025 at 9:13 a.m., in Resident 42's room, observed Resident 42 lying in bed. Resident 42's call light was observed on the floor behind Resident 42's bed. Resident 42's call light was not within reach. During a review of Resident 42's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 42 Resident 42 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), muscle weakness, and dysphagia (difficulty swallowing). During a review of Resident 42's Minimum Data Set ([MDS]- a resident assessment tool), dated 1/8/2024, the MDS indicated Resident 42's cognitive skills for daily living was moderately impaired (ability to think and reason). The MDS indicated Resident 42 required moderate assistance from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 42's care plan with a focus of Resident at risk for falls, revised 6/21/2024, the care plan indicated Resident 42 was at risk for falls related to impaired cognition and was not steady during ambulation (walking). The care plan intervention indicated the facility would provide the call light within Resident 42's reach and encourage the resident to use it often. During a concurrent observation and interview on 1/27/2025 at 10:17 a.m., with Certified Nursing Assistant (CNA 4), in Resident 42's room, Resident 42 was observed sitting on the bed. CNA 4 stated Resident 42 was seating on the bed, and Resident 42's call light was observed on the floor behind Resident 42's bed, not within reach. CNA 4 stated Resident 42's call light should have been attached to the resident bed and within reach. CNA 4 stated it was important that resident was able to reach the call light and was able to use it when assistance needed, for an emergency. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/30/2025 at 2:20 p.m., with Registered Nurse (RN 1), the RN 1 stated the call light should be placed within resident reach and the near the resident's bedside. RN 1 stated the call light was important for resident's to be able to communicate with the staff. RN 1 stated the facility's licensed staff were responsible for checking the residents' call light and placing it within resident reach at the bedside. RN 1 stated if the call light not within the resident's reach, the residents would not be able to use the call light and would not be able to call for help and assistance when needed. RN 1 stated the call light not within reach was a resident safety issue, and placed residents at risk for falls and injury. During a review of the facility's policy and procedure (P&P) titled Answering the Call Light, revised 10/2010, the P&P indicated the facility would ensure when the resident was in bed the call light would be within easy reach of the resident.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on interview and record review, the facility failed to notify the California Department of Public Health (CDPH), law enforcement, and the ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities) when the facility failed to provide necessary services to prevent potential physical harm, pain, mental anguish, or emotional distress for one of one sampled resident (Resident 118) that resulted in: 1. Resident 118 eloping (the act of leaving a facility unsupervised and without prior authorization) from the facility on 10/13/2024. 2. Resident 118 eloping from the facility, a second time, on 11/24/2024. These deficient practices resulted in a delay of an onsite inspection by CDPH and involvement of law enforcement to assist in locating Resident 118 and had the potential for Resident 118 to Resident 118 to suffer medical complications such as malnutrition, dehydration, stroke, exposure to harsh environmental conditions including excessive cold, fire, possible motor vehicle accident, and and/or possible death. Findings: During a review of Resident 118's Admission Record (Face Sheet), the Face Sheet indicated Resident 118 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), psychoactive substance-induced persisting dementia (a deterioration of mental function resulting from the persisting effects of alcohol use), and altered mental status (a change in mental function, such as a decline in awareness, attention, or consciousness). During a review of Resident 118's Minimum Data Set ([MDS], a resident assessment tool), dated 10/3/2024, the MDS indicated Resident 118's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 118 normally used a walker (a mobility aide that helps people walk by providing stability and balance). The MDS indicated Resident 118 required moderate assistance (helper does less than half the effort) with toileting, bathing, lower body dressing, and putting on and taking off footwear. During a review of Resident 118's Progress Note, dated 10/13/2024 and timed 4:45 p.m., the Progress Note indicated on 11/24/2024 at 3:30 p.m., Resident 118 was not in his room and was last seen on the smoking patio at 3 p.m. The Progress Note indicated Resident 118 did not have an out on pass order and staff checked within the facility and the surrounding areas. The Progress Note indicated Resident 118 was unable to be found. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 118's Progress Note, dated 11/24/2024 and timed at 7:24 p.m., the Progress Note indicated on 11/24/2024 at 3:35 p.m., Resident 118 was nowhere to be found within the facility. The Progress Note indicated Resident 118 stepped out of the facility unsupervised and undetected [for] the second time. The Progress Note indicated staff make thorough search inside and outside the facility. The Progress Note indicated Resident 118's physician was made aware and instructed to report the incident to the police. During an interview on 1/27/2025 at 1:44 p.m., with Registered Nurse (RN) 1, RN 1 stated she the RN on duty on 10/13/2024 when Resident 118 eloped from the facility. RN 1 stated she was unaware how Resident 118 eloped. RN 1 stated one of the required services the facility had to provide to all residents was to provide monitoring in the facility to ensure their safety. RN 1 stated on 10/13/2024, she realized Resident 118 was not in his room nor anywhere else within the facility. RN 1 stated many of the facility's staff searched within the facility and went out into the surrounding areas to try to locate Resident 118. RN 1 stated she informed the Director of Nursing (DON) and the Administrator (ADM) of the incident and was instructed not to alert the authorities. RN 1 stated informing law enforcement was important so they would be aware of the situation and to assist in locating Resident 118 by utilizing their ability to contact hospitals and other facilities. RN 1 stated the ADM and/or the DON would be responsible for informing CDPH and the ombudsman so both entities would be aware and so an onsite inspection could occur to assess the facility's actions. During a concurrent interview and record review on 1/31/2025 at 10:12 a.m., with the Administrator (ADM), the facility's policy and procedure (P&P) titled, Abuse and Neglect, revised 3/2018, was reviewed. The P&P indicated, 'Neglect' [means], 'the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. The ADM stated the facility was supposed to provide services to Resident 118 to prevent him from eloping that included monitoring Resident 118, identifying his inappropriate room placement and his physical abilities to effectively exit the facility, documentation of Resident 118's monitoring and supervision, updating Resident 118's care plans (document that helps nurses and other team care members organize aspects of resident care) with interventions to properly care for Resident 118, conduct an interdisciplinary care team ([IDT], a group of different disciplines working together towards a common goal for a resident) meeting to determine Resident 118's goals and address Resident 118's needs, and address Resident 118's psychosocial wellbeing. The ADM stated the facility failed to provide routine and frequent monitoring to Resident 118 and failed to follow-up on Resident 118's psychosocial, emotional, and physical needs and concerns. The ADM stated the facility failed to provide the necessary services to keep Resident 118 from eloping from the facility, which put Resident 118 at risk of exposure to extreme weather, motor vehicle accident, and death. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/31/2025 at 10:27 a.m., with the ADM, the facility's P&P titled, Abuse Investigation and Reporting, dated 7/2017, was reviewed. The P&P indicated, All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and/or injuries of unknown source shall be promptly reported to local, state, and federal agencies (as defined by current regulations). The P&P indicated an alleged violation of neglect would be reported immediately but not later than twenty-four hours if the alleged violation did not involve abuse and had not resulted in serious bodily injury. The ADM stated the facility neglected to provide the necessary services to keep Resident 118 from eloping from the facility on 10/13/2024 and 11/24/2024, which placed Resident 118 at risk for physical harm and death. The ADM stated Resident 118's elopement on 10/13/2024 was not reported to CDPH, law enforcement, nor the ombudsman. The ADM stated Resident 118's elopement on 11/24/2024 was not reported to CDPH nor the ombudsman. The ADM stated the facility was responsible for reporting both incidents to CDPH, law enforcement, and the ombudsman to be provided additional assistance in locating Resident 118 and for an onsite visit to occur to assess the facility's compliance with the current regulations to ensure the safety of not only Resident 118 but all the residents in the facility. Cross Reference F689 and F610.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on interview and record review, the facility failed to safely discharge three of six sampled residents (Residents 117, 320, and 321) when: 1. The facility discharged Resident 117 from the facility, without his knowledge, request, or consent, on 11/9/2024. 2. The facility discharged Resident 320 from the facility, without his knowledge, request, or consent, on 10/13/2024. 3. The facility discharged Resident 321 from the facility, without his knowledge, request, or consent, on 10/7/2024. These deficient practices placed all three residents at risk for avoidable physical and psychosocial harm due to their discharge without confirmation of their whereabouts and/or safety, and no notification provided to the residents, local law enforcement agencies, the State Agency, or the Ombudsman (a neutral third party who investigates and resolves complaints) for further follow-up. These deficient practices also placed facility residents and staff at risk when Resident 117 returned to the facility on [DATE] brandishing a large knife. Findings: 1. During a review of Resident 117's Admission Record, the Admission Record indicated Resident 117 was admitted on [DATE]. Resident 117's diagnoses included a broken right thigh bone and displacement of internal fixation device of the right thigh bone (when a surgical implant, like a plate, screw, or rod used to stabilize a broken bone, has moved out of its original position). During a review of Resident 117's History and Physical (H&P), dated 5/7/2024, the H&P indicated Resident 117 had the capacity to understand and make decisions. During a review of Resident 117's discharge Minimum Data Set (MDS, a resident assessment tool), dated 11/9/2024, the MDS indicated Resident 117 was independent in making decisions regarding tasks of daily life, and his decisions were consistent and reasonable. The MDS indicated Resident 117 did not exhibit wandering behavior or rejection of care. The MDS indicated Resident 117 was independent with activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) and mobility while in and out of bed. During a review of Resident 117's psychiatric progress note, dated 11/7/2024, the progress note indicated Resident 117 had major depressive disorder (a mental health condition characterized by persistent feelings of sadness, loss of interest, and other symptoms that significantly interfere with daily life) and verbalized depressive episodes (a period of time when a person experiences a depressed mood and other symptoms of depression for at least two weeks) related to not having a place to stay in the community. The progress note indicated social services was working on relocating Resident 117 back into the community. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 117's physician order, dated 10/3/2024, the order indicated Resident 117 was permitted to leave the facility out on pass (OOP), not to exceed four hours. During a review of Resident 117's social services progress note, dated 11/8/2024 at 3:49 p.m., the progress note indicated the Social Services Director (SSD) spoke with Resident 117 about his order to leave the facility OOP, and the time limit of four hours. The progress note indicated the SSD spoke with Resident 117 about referring him to a housing coordinator to assist with transition back into the community. The progress note did not indicate Resident 117 expressed a desire to be discharged , or intentions to not return to the facility from his four-hour OOP leave. During a review of Resident 117's progress note, dated 11/9/2024 at 12:33 a.m., the progress note indicated Resident 117 was out of the facility on an approved OOP four-hour leave and did not return within four hours. The progress note indicated staff attempts to contact Resident 117 were unsuccessful. The progress note indicated Resident 117 was discharged from the facility against medical advice (AMA, a situation where a patient leaves a healthcare facility or discontinues treatment without the consent or recommendation of their healthcare provider). The progress note did not indicate information related to the discharge was communicated to Resident 117. During a review of Resident 117's physician order, dated 11/9/2024, the order indicated Resident 117 was discharged AMA due to exceeding the OOP four-hour time limit. The order indicated staff attempted to contact Resident 117 via cellular telephone and there was no response. During a review of Resident 117's progress note, dated 11/9/24 at 7:15 a.m., the progress note indicated Resident 117 returned to the facility and went to his room. The progress note indicated Resident 117 was informed he was discharged and that his presence on the facility premises was trespassing. The progress note indicated Registered Nurse (RN) 1 contacted law enforcement, and law enforcement removed Resident 117 from the facility. The progress note indicated Resident 117 left with some of his belongings, and that he was told he could pick up his remaining belongings on 11/11/2024. During a review of Resident 117's progress note, dated 11/9/24 at 2:26 p.m., the progress note indicated Resident 117 returned to the facility and was very aggressive and brandishing a large knife. The progress note indicated Resident 117 was yelling expletives (curse words). The progress note indicated law enforcement was contacted but never arrived. The progress note indicated Resident 117 collected the remainder of his belongings and left the facility premises. On 1/31/2024 at 9:29 a.m., an attempt was made to contact Resident 117 by telephone. Resident 117's contact number was disconnected. During an interview on 1/31/2025 at 10:16 a.m., with RN 1, RN 1 stated a discharge AMA was initiated if a resident expressed a desire to leave the facility. RN 1 stated an AMA discharge required facility staff to explain the risks and benefits of leaving the facility to the resident, and stated the resident would be encouraged to stay in the facility. RN 1 stated an AMA discharge was to be requested by the resident and was not to be initiated by facility staff. RN 1 stated Resident 117's discharge was not safe. RN 1 stated discharging Resident 117 AMA indicated the discharge was Resident 117's choice, and stated this was not confirmed with Resident 117. RN 1 stated a discharge AMA also indicated there would be no attempt to search for the resident or involve any other agencies to ensure the resident's well-being. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 1/31/2025 at 11:15 a.m., with the SSD, the SSD stated an AMA discharge was initiated if a resident expressed a desire to leave the facility immediately. The SSD stated she was arranging discharge housing for Resident 117 prior to his discharge from the facility on 11/9/2024 and stated they had planned to review housing paperwork on Monday, 11/11/2024. The SSD stated that discharging a resident without a place to go was dangerous. The SSD stated the resident could be exposed to crime and poor weather conditions, which could negatively impact their safety and well-being. During an interview on 1/31/2025 at 1:02 p.m., with the Medical Records Director (MRD), the MRD stated Resident 117 did not sign an AMA acknowledgment form (a document that a patient signs to acknowledge their decision to leave a healthcare facility against their doctor's advice) at the time he was discharged because he was not in the facility and was unable to be contacted by telephone. During an interview on 1/31/2025 at 12:05 p.m., with the Director of Nursing (DON), the DON stated multiple attempts to reach Resident 117 were unsuccessful prior to the facility's decision to discharge Resident 117 AMA. The DON stated the facility did not know Resident 117's whereabouts, or if there was a reason he did not return within the four-hour timeframe, when the facility discharged him. The DON stated Resident 117's discharge was not safe. 2. During a review of Resident 320's Admission Record, the Admission Record indicated Resident 320 was admitted to the facility on [DATE]. Resident 320's admitting diagnoses included generalized muscle weakness, abnormalities of gait (the way someone walks, runs, or jogs) and mobility, right foot drop (a condition where the foot is unable to lift off the ground due to weakness or paralysis of the muscles), discitis (an infection and/or inflammation of the space between the spinal bones), and type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 320's H&P, dated 9/13/2024, the H&P indicated Resident 320 had the capacity to understand and make decisions. During a review of Resident 320's admission MDS, dated [DATE], the MDS indicated Resident 320 did not have cognitive impairments (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 320 required partial to moderate assistance from staff for mobility while in and out of bed, including to walk 10 feet. The MDS indicated Resident 320 was not assessed for his ability to transfer in and out of a vehicle, or to walk 50 feet or 150 feet, due to medical conditions and/or safety concerns. During a review of Resident 320's discharge MDS, dated [DATE], the MDS indicated Resident 320 was independent in making decisions regarding tasks of daily life, and his decisions were consistent and reasonable. The MDS indicated Resident 320 did not exhibit wandering behavior or rejection of care. The MDS indicated Resident 320 required partial to moderate assistance from staff for mobility, including to walk 10 feet. The MDS indicated Resident 320 was not assessed for his ability to transfer in and out of a vehicle, walk 50 feet or 150 feet, walk on uneven surfaces (outdoor or indoor), or to go up and down a step or curb, due to medical conditions and/or safety concerns. During a review of Resident 320's case management progress note, dated 10/3/2024, the progress note indicated Resident 320 was refusing to be discharged home. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 320's Nursing Weekly Summary assessment, dated 10/7/2024, the assessment indicated Resident 320 required a wheelchair and did not display any behavior concerns related to his admission at the facility. The assessment indicated Resident 320 was receiving physical therapy and occupational therapy services, with slow steady progress. The assessment indicated Resident 320 required blood sugar level monitoring on all shifts. During a review of Resident 320's progress note, dated 10/11/2024 at 9:57 a.m., the progress note indicated Resident 320 requested to leave the facility OOP, and indicated Resident 320's physician ordered an OOP leave, not to exceed four hours. During a review of Resident 320's progress note, dated 10/12/2024 at 2:23 p.m., the progress note indicated Resident 320 left the facility OOP at 2:00 p.m., in stable condition. The progress note did not indicate Resident 320 expressed a desire to be discharged from the facility or an intent to not return. During a review of Resident 320's progress note, dated 10/12/2024 at 8:48 p.m., the progress note indicated Resident 320 had not yet returned to the facility. The progress note indicated the facility did not have a contact number to reach Resident 320 by phone, and did not have an alternate emergency contact to call. The progress note did not indicate the facility had been in contact with Resident 320. During a review of Resident 320's progress note, dated 10/12/2024 at 11:28 p.m., the progress note indicated Resident 320 had not yet returned to the facility. The progress note indicated the facility did not have a contact number to reach Resident 320 by phone, and did not have an alternate emergency contact to call. The progress note did not indicate the facility had been in contact with Resident 320. During a review of Resident 320's physician order, dated 10/13/2024, the order indicated staff were to discharge Resident 320 AMA. During a review of Resident 320's progress note, dated 10/13/2024 at 12:00 a.m., the progress note indicated Resident 320 was discharged AMA. The progress note did not indicate the facility had been in contact with Resident 320 since he departed the facility on 10/12/2024. The progress note did not indicate the facility was aware of why Resident 320 had not returned. During a concurrent interview and record review, on 1/31/2025 at 1:52 p.m., with the DON, Resident 320's progress notes dated 10/12/2024 and 10/13/2024 were reviewed. The DON stated the progress notes did not indicate Resident 320 expressed a desire to be discharged , and stated there was no documentation indicating Resident 320's safety, well-being, or disposition were identified by facility staff prior to his discharge on 10/13/2024. The DON stated Resident 320 was not explained the risks related to an AMA discharge, and stated Resident 320's discharge was not safe. The DON stated Resident 320's whereabouts remained unknown at the time of the interview. 3. During a review of Resident 321's Admission Record, the Admission Record indicated Resident 321 was admitted on [DATE]. Resident 321's admitting diagnoses included generalized muscle weakness, abnormalities of gait and mobility, and peripheral vascular disease (a slow progressive narrowing of the blood flow to the arms and legs). (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 321's H&P, dated 9/7/2024, the H&P did not indicate if Resident 321 had the capacity to understand and make decisions. During a review of Resident 321's admission MDS, dated [DATE], the MDS indicated Resident 321 did not have cognitive impairments. The MDS indicated Resident 321 could walk distances of 10 feet and 50 feet with staff assistance prior to or following the activity. The MDS indicated Resident 321 was not assessed for his ability to transfer in and out of a vehicle or walk 150 feet due to medical conditions and/or safety concerns. During a review of Resident 321's admission MDS, dated [DATE], the MDS indicated Resident 321 was independent in making decisions regarding tasks of daily life, and his decisions were consistent and reasonable. The MDS indicated Resident 321 did not exhibit wandering behavior or rejection of care. The MDS indicated Resident 321 could walk distances of 10 feet and 50 feet with staff assistance prior to or following the activity. The MDS indicated Resident 321 was not assessed for his ability to transfer in and out of a vehicle, walk 150 feet, walk on uneven surfaces (outdoor or indoor), or to go up and down a step or curb, due to medical conditions and/or safety concerns. During a review of Resident 321's physician order, dated 9/12/2024, the order indicated Resident 321 was permitted to leave the facility OOP, not to exceed four hours. During a review of Resident 321's progress note, dated 10/5/2024 at 11:00 a.m., the progress note indicated Resident 321 left the facility OOP in an electric wheelchair. The progress note indicated Resident 321 was alert and aware he was expected to return within four hours. During a review of Resident 321's progress note, dated 10/6/2024 at 7:33 a.m., the progress note indicated that on 10/5/2024 during the 3:00 p.m. to 11:00 p.m. shift, Resident 321 returned to the facility and then departed OOP a second time. The progress note did not indicate the exact time of Resident 321's second departure on 10/5/2024. The progress note indicated Resident 321 contacted the facility during his second OOP leave on 10/5/2024 and informed staff he would be returning to the facility on [DATE] around 9:00 a.m. The progress note indicated that on 10/6/2024 at 7:33 a.m., Resident 321 had not returned to the facility. During a review of Resident 321's progress note, dated 10/6/2024 at 3:15 p.m., the progress note indicated the resident had not yet returned to the facility. The progress note did not indicate contact was made with Resident 321. During a review of Resident 321's social service progress note, dated 10/8/2024 at 2:32 p.m., the progress note indicated the SSD notified Resident 321's daughter that Resident 321 did not return to the facility from his OOP leave, and indicated Resident 321 was discharged AMA. During an interview on 1/31/2025 at 1:59 p.m., with Licensed Vocational Nurse (LVN) 5, LVN 5 stated Resident 321 left on 10/5/2024 during her shift. LVN 5 stated Resident 321 did not express a desire to be discharged from the facility or that he did not intend to return. LVN 5 stated that if he wanted to be discharged , staff would have explained the risks of leaving AMA and asked him to sign the AMA acknowledgement form. LVN 5 stated Resident 321 did not sign an AMA acknowledgement form. LVN 5 stated Resident 321 returned to the facility in November, a month after he was discharged AMA. LVN 5 stated Resident 321 was angry and appeared dirty as if he was living on the street. LVN 5 stated Resident 321 came to pick up his belongings. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review, on 1/31/2025 at 2:08 p.m., with the DON, Resident 321's progress notes dated 10/5/2024 to 10/6/2024, and census, were reviewed. The DON stated the progress notes indicated Resident 321 informed the facility of his intent to return on 10/5/2024 while he was on OOP. The DON stated the progress notes did not indicate Resident 321 requested to be discharged . The DON stated the progress notes did not indicate any contact was made with Resident 321 after his last contact on 10/5/24 or prior to his discharge on 10/7/2024. The DON stated the census indicated Resident was discharged after 12:00 a.m. on 10/7/2024. During a concurrent interview and record review, on 1/31/2025 at 12:05 p.m., with the DON, the facility policy and procedure (P&P) titled Discharging a Resident without a Physician's Approval, revised 2012, and the facility document titled Leaving Against Medical Advice, undated, were reviewed. The DON stated the P&P revised 2012 defined an AMA discharge and outlined the process for an AMA discharge. The DON stated the P&P indicated an AMA discharge required a resident (or their responsible party) to request an immediate discharge and required the resident to sign a release of responsibility form. The DON stated the facility document titled Leaving Against Medical Advice was the facility's release of responsibility form, and stated the form required the resident to acknowledge being informed of the risks involved in leaving the facility AMA. The DON stated the facility's process was to discharge AMA any resident who left the facility OOP, and did not return to the facility within four hours or by midnight. The DON stated law enforcement, the State Agency, and the Ombudsman were not notified of the resident's departure from the facility if discharged AMA. The DON stated that based on the facility P&P revised 2012, Resident 117, Resident 320, and Resident 321 did not meet the criteria for an AMA discharge. During a review of the facility P&P titled Discharging a Resident without a Physician's Approval, revised 2012, the P&P indicated that if a resident or their responsible party insisted upon being discharged , the resident and/or their responsible party were supposed to sign a release of responsibility form. During a review of the facility P&P titled Transfer or Discharge Orientation, revised 9/2012, the P&P indicated it was the facility policy to prepare a resident for transfer or discharge, and staff were to orient the resident of the plan for discharge to ensure a safe and orderly discharge from the facility. During a review of the facility document titled Leaving Against Medical Advice, undated, the document indicated a resident's, and/or their responsible party's, signature would indicate they had been informed of the risks involved with leaving AMA, and they released the facility from all responsibility and any ill effects that could result from leaving. During a review of the facility P&P titled Transfer or Discharge Notice, undated, the P&P indicated the facility was to provide the resident with a 30-day written notice of an impending transfer or discharge. The P&P indicated there were exceptions this notification, and the exceptions did not include failure to return to the facility by midnight while OOP. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility P&P titled Transfer or Discharge, Preparing a Resident for, revised 2013, the P&P indicated it was the facility policy to prepare residents for transfer or discharge. The P&P indicated staff were to assist the resident with transportation, escort the resident to transportation, prepare a discharge summary, and provide the resident with required documents. The P&P indicated staff were to inform appropriate departments and others, as necessary, of the resident's discharge. Cross Reference F-tags F689 and F623.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on interview and record review, the facility failed to provide advance notice of discharge to three of six sampled residents (Residents 117, 320, and 321) and the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities). This deficient practice placed all three residents at risk for avoidable physical and psychosocial harm due to their discharge from the facility, without sufficient time for housing, transportation, and/or care arrangements to be made. The deficient practice also prevented the Ombudsman (a neutral third party who investigates and resolves complaints) from being aware of the need for follow-up related to the unsafe discharges. Findings: 1. During a review of Resident 117's Admission Record, the Admission Record indicated Resident 117 was admitted on [DATE]. Resident 117's diagnoses included a broken right thigh bone and displacement of internal fixation device of the right thigh bone (when a surgical implant, like a plate, screw, or rod used to stabilize a broken bone, has moved out of its original position). During a review of Resident 117's History and Physical (H&P), dated 5/7/2024, the H&P indicated Resident 117 had the capacity to understand and make decisions. During a review of Resident 117's discharge Minimum Data Set (MDS, a resident assessment tool), dated 11/9/2024, the MDS indicated Resident 117 was independent in making decisions regarding tasks of daily life, and his decisions were consistent and reasonable. The MDS indicated Resident 117 did not exhibit wandering behavior or rejection of care. The MDS indicated Resident 117 was independent with activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) and mobility while in and out of bed. During a review of Resident 117's psychiatric progress note, dated 11/7/2024, the progress note indicated Resident 117 had major depressive disorder (a mental health condition characterized by persistent feelings of sadness, loss of interest, and other symptoms that significantly interfere with daily life), and verbalized depressive episodes (a period of time when a person experiences a depressed mood and other symptoms of depression for at least two weeks) related to not having a place to stay in the community. The progress note indicated social services was working on relocating Resident 117 back into the community. During a review of Resident 117's physician order, dated 10/3/2024, the order indicated Resident 117 was permitted to leave the facility out on pass (OOP), not to exceed four hours. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 320's Nursing Weekly Summary assessment, dated 10/7/2024, the assessment indicated Resident 320 required a wheelchair and did not display any behavior concerns related to his admission at the facility. The assessment indicated Resident 320 was receiving physical therapy and occupational therapy services, with slow steady progress. The assessment indicated Resident 320 required blood sugar level monitoring on all shifts. During a review of Resident 320's progress note, dated 10/11/2024 at 9:57 a.m., the progress note indicated Resident 320 requested to leave the facility OOP, and indicated Resident 320's physician ordered an OOP leave, not to exceed four hours. During a review of Resident 320's progress note, dated 10/12/2024 at 2:23 p.m., the progress note indicated Resident 320 left the facility OOP at 2:00 p.m., in stable condition. The progress note did not indicate Resident 320 expressed a desire to be discharged from the facility or an intent to not return. During a review of Resident 320's progress note, dated 10/12/2024 at 8:48 p.m., the progress note indicated Resident 320 had not yet returned to the facility. The progress note indicated the facility did not have a contact number to reach Resident 320 by phone, and did not have an alternate emergency contact to call. The progress note did not indicate the facility had been in contact with Resident 320. During a review of Resident 320's progress note, dated 10/12/2024 at 11:28 p.m., the progress note indicated Resident 320 had not yet returned to the facility. The progress note indicated the facility did not have a contact number to reach Resident 320 by phone, and did not have an alternate emergency contact to call. The progress note did not indicate the facility had been in contact with Resident 320. During a review of Resident 320's physician order, dated 10/13/2024, the order indicated staff were to discharge Resident 320 AMA. During a review of Resident 320's progress note, dated 10/13/2024 at 12:00 a.m., the progress note indicated Resident 320 was discharged AMA. The progress note did not indicate the facility had been in contact with Resident 320 since he departed the facility on 10/12/2024. The progress note did not indicate the facility was aware of why Resident 320 had not returned. During a concurrent interview and record review, on 1/31/2025 at 1:52 p.m., with the DON, Resident 320's progress notes dated 10/12/2024 and 10/13/2024 were reviewed. The DON stated the progress notes did not indicate Resident 320 expressed a desire to be discharged , and stated there was no documentation indicating Resident 320's safety, well-being, or disposition were identified by facility staff prior to his discharge on 10/13/2024. The DON stated Resident 320 was not explained the risks related to an AMA discharge, and stated Resident 320's discharge was not safe. The DON stated Resident 320's whereabouts remained unknown at the time of the interview. 3. During a review of Resident 321's Admission Record, the Admission Record indicated Resident 321 was admitted on [DATE]. Resident 321's admitting diagnoses included generalized muscle weakness, abnormalities of gait and mobility, and peripheral vascular disease (a slow progressive narrowing of the blood flow to the arms and legs). (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 321's H&P, dated 9/7/2024, the H&P did not indicate if Resident 321 had the capacity to understand and make decisions. During a review of Resident 321's admission MDS, dated [DATE], the MDS indicated Resident 321 did not have cognitive impairments. The MDS indicated Resident 321 could walk distances of 10 feet and 50 feet with staff assistance prior to or following the activity. The MDS indicated Resident 321 was not assessed for his ability to transfer in and out of a vehicle or walk 150 feet due to medical conditions and/or safety concerns. During a review of Resident 321's admission MDS, dated [DATE], the MDS indicated Resident 321 was independent in making decisions regarding tasks of daily life, and his decisions were consistent and reasonable. The MDS indicated Resident 321 did not exhibit wandering behavior or rejection of care. The MDS indicated Resident 321 could walk distances of 10 feet and 50 feet with staff assistance prior to or following the activity. The MDS indicated Resident 321 was not assessed for his ability to transfer in and out of a vehicle, walk 150 feet, walk on uneven surfaces (outdoor or indoor), or to go up and down a step or curb, due to medical conditions and/or safety concerns. During a review of Resident 321's physician order, dated 9/12/2024, the order indicated Resident 321 was permitted to leave the facility OOP, not to exceed four hours. During a review of Resident 321's progress note, dated 10/5/2024 at 11:00 a.m., the progress note indicated Resident 321 left the facility OOP in an electric wheelchair. The progress note indicated Resident 321 was alert and aware he was expected to return within four hours. During a review of Resident 321's progress note, dated 10/6/2024 at 7:33 a.m., the progress note indicated that on 10/5/2024 during the 3:00 p.m. to 11:00 p.m. shift, Resident 321 returned to the facility and then departed OOP a second time. The progress note did not indicate the exact time of Resident 321's second departure on 10/5/2024. The progress note indicated Resident 321 contacted the facility during his second OOP leave on 10/5/2024 and informed staff he would be returning to the facility on [DATE] around 9:00 a.m. The progress note indicated that on 10/6/2024 at 7:33 a.m., Resident 321 had not returned to the facility. During a review of Resident 321's progress note, dated 10/6/2024 at 3:15 p.m., the progress note indicated the resident had not yet returned to the facility. The progress note did not indicate contact was made with Resident 321. During a review of Resident 321's social service progress note, dated 10/8/2024 at 2:32 p.m., the progress note indicated the SSD notified Resident 321's daughter that Resident 321 did not return to the facility from his OOP leave, and indicated Resident 321 was discharged AMA. During an interview on 1/31/2025 at 1:59 p.m., with Licensed Vocational Nurse (LVN) 5, LVN 5 stated Resident 321 left on 10/5/2024 during her shift. LVN 5 stated Resident 321 did not express a desire to be discharged from the facility or that he did not intend to return. LVN 5 stated that if he wanted to be discharged , staff would have explained the risks of leaving AMA and asked him to sign the AMA acknowledgement form. LVN 5 stated Resident 321 did not sign an AMA acknowledgement form. LVN 5 stated Resident 321 returned to the facility in November, a month after he was discharged AMA. LVN 5 stated Resident 321 was angry and appeared dirty as if he was living on the street. LVN 5 stated Resident 321 came to pick up his belongings. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review, on 1/31/2025 at 2:08 p.m., with the DON, Resident 321's progress notes dated 10/5/2024 and 10/6/2024 were reviewed. The DON stated the progress notes indicated Resident 321 informed the facility of his intent to return on 10/5/2024 while he was on OOP. The DON stated the progress notes did not indicate Resident 321 requested to be discharged . The DON stated the progress notes did not indicate any contact was made with Resident 321 after his last contact on 10/5/24 or prior to his discharge on 10/6/2024. During a concurrent interview and record review, on 1/31/2025 at 12:05 p.m., with the DON, the facility policy and procedure (P&P) titled Discharging a Resident without a Physician's Approval, revised 2012, and the facility document titled Leaving Against Medical Advice, undated, were reviewed. The DON stated the P&P revised 2012 defined an AMA discharge and outlined the process for an AMA discharge. The DON stated the P&P indicated an AMA discharge required a resident (or their responsible party) to request an immediate discharge and required the resident to sign a release of responsibility form. The DON stated the facility document titled Leaving Against Medical Advice was the facility's release of responsibility form, and stated the form required the resident to acknowledge being informed of the risks involved in leaving the facility AMA. The DON stated that despite the P&P, revised 2012, the facility's process was to discharge any resident AMA if they left the facility OOP, and did not return to the facility within four hours or by midnight. The DON stated law enforcement, the State Agency, and the Ombudsman were not notified of the resident's departure from the facility if discharged AMA. The DON stated that based on the facility P&P, revised 2012, Resident 117, Resident 320, and Resident 321 did not meet the criteria for an AMA discharge and stated the Ombudsman was not notified of any of the residents' discharges. During a review of the facility P&P titled Discharging a Resident without a Physician's Approval, revised 2012, the P&P indicated that if a resident or their responsible party insisted upon being discharged , the resident and/or their responsible party were supposed to sign a release of responsibility form. During a review of the facility P&P titled Transfer or Discharge Notice, undated, the P&P indicated the facility was to provide the resident with a 30-day written notice of an impending transfer or discharge. The P&P indicated there were exceptions this notification, and the exceptions did not include failure to return to the facility by midnight while OOP. During a review of the facility P&P titled Transfer or Discharge Orientation, revised 9/2012, the P&P indicated it was the facility policy to prepare a resident for transfer or discharge, and staff were to orient the resident of the plan for discharge to ensure a safe and orderly discharge from the facility. During a review of the facility P&P titled Transfer or Discharge, Preparing a Resident for, revised 2013, the P&P indicated it was the facility policy to prepare residents for transfer or discharge. The P&P indicated staff were to assist the resident with transportation, escort the resident to transportation, prepare a discharge summary, and provide the resident with required documents. The P&P indicated staff were to inform appropriate departments and others, as necessary, of the resident's discharge. Cross Reference F-tags F689 and F622.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on interview and record review, the facility failed to accurately complete the minimum data set (MDS - a resident assessment tool) assessment Section I (active diagnoses) by failing to include a diagnosis of depression per information in the medical record for one of five residents sampled for unnecessary medications (Resident 36). The deficient practice of failing to accurately assess active diagnoses and complete MDS Section I increased the risk that Resident 36 may not have received care planning and treatment according to her needs possibly leading to a decline in her overall health and well-being. Findings: During a review of Resident 36's Admission Record (a document containing a resident's diagnostic and demographic information), dated 1/29/2025, the admission record indicated the resident was admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses including paranoid schizophrenia (a mental illness characterized by hearing or seeing things that are not there). During a review of Resident 36's History and Physical (H&P - a record of a comprehensive physician's assessment), dated 11/23/2024, the H&P indicated the resident had the capacity to understand and make decisions. The H&P indicated Resident 36 also had the diagnosis of depression (a mental disorder characterized by depressed mood, poor appetite, difficulty sleeping, and lack of interest in normally enjoyable activities). During a review of Resident 36's Psychiatric Note (a medical progress assessment written by a psychiatric care provider) dated 12/7/2024, the psychiatric note indicated the resident's psychiatric diagnoses included paranoid schizophrenia and major depression. During a review of Resident 36's Physician Order Summary (a monthly summary of all active physician orders), dated 1/29/2025, the physician order summary indicated the resident was prescribed Cymbalta (a medication used to treat depression) 30 milligrams (mg - a unit of measure for mass) by mouth once daily for depression manifested by verbalization of sadness on 11/22/2024. During a review of Resident 36's Minimum Data Set (MDS, a resident assessment tool) Section I, dated 12/10/2024, the MDS indicated Resident 36 did not have depression as an active diagnosis. During an interview on 1/29/2025 at 12:51 p.m. with the Director of Nursing (DON), the DON stated Resident 36's MDS section I, dated 12/10/2024, was inaccurate as it did not include depression as one of the resident's active diagnoses. The DON stated Resident 36 had a diagnosis of depression based on documentation in the medical record, but the MDS assessment indicated Resident 36 did not. The DON stated there was a risk that a resident's needs may not be adequately addressed through a care plan if the MDS assessment was inaccurate which could lead to a decline in the resident's physical, mental, or psychosocial status. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's undated policy and procedure (P&P) titled Resident Assessment Instrument, the P&P indicated A comprehensive assessment of a resident's needs shall be made within fourteen (14) days of the resident's admission . Information derived from the comprehensive assessment helps the staff to plan care that allows the resident to reach his/her highest practicable level of functioning .

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on interview and record review, the facility failed to accurately complete the Preadmission Screening and Resident Review (PASARR - a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) level I screening by omitting a diagnosis of schizophrenia (a mental illness characterized by hearing or seeing things that are not there) for two of five residents sampled for unnecessary medications (Residents 1 and 36). The deficient practice of failing to accurately complete the PASARR Level I screening increased the risk that Residents 1 and 36 could have failed to receive special psychiatric services related to their diagnosis of schizophrenia possibly leading to a decline in their overall health and well-being. Findings: During a review of Resident 1's Admission Record (a record containing diagnostic and demographic resident information), dated 1/29/2025, the admission record indicated the resident was admitted to the facility on [DATE] with diagnoses including schizophrenia (a mental illness characterized by hearing or seeing things that are not there) and major depressive disorder (MDD - a mental illness characterized by depressed mood, lack of interest in activities, poor appetite, and/or trouble sleeping). During a review of Resident 1's Psychiatric Note (a medical progress assessment written by a psychiatric care provider) dated 1/2/2025, the psychiatric note indicated the resident had the capacity to understand and make decisions unless exacerbation of paranoid thoughts. Further review of the psychiatric note indicated Resident 1's psychiatric diagnoses included schizophrenia, unspecified. During a review of Resident 1's Order Summary Report (a summary of all current physician orders), dated 1/29/2025 the order summary report indicated, on 7/1/2023, Resident 1's attending physician prescribed olanzapine 10 milligrams (mg - a unit of measure for mass) by mouth at bedtime for auditory hallucinations (hearing things that are not there) as evidenced by hearing voices related to schizophrenia . During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) assessment Section I (active diagnoses), dated 11/25/2024, the MDS indicated schizophrenia was currently an active diagnosis. During a review of Resident 1's PASARR Level I Screening, dated 12/19/2024, the PASARR indicated the resident did not have a serious mental illness (such as schizophrenia) and was not prescribed psychotropic (medications that affect brain activities associated with mental processed and behavior) medication. During a review of Resident 36's Admission Record, dated 1/29/2025, the admission record indicated the resident was admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses including paranoid schizophrenia. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 36's History and Physical (H&P - a record of a comprehensive physician's assessment), dated 11/23/2024, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 36's Psychiatric Note dated 12/7/2024, the psychiatric note indicated the resident's psychiatric diagnoses included paranoid schizophrenia and major depression. During a review of Resident 36's Physician Order Summary, dated 1/29/2025, the order summary indicated, on 12/18/2024, the resident was prescribed olanzapine 5 mg by mouth at bedtime for paranoid schizophrenia manifested by striking out at peers. During a review of Resident 36's MDS Section I, dated 12/10/2024, the MDS indicated schizophrenia was currently an active diagnosis. During a review of Resident 36's PASARR Level I Screening, dated 12/18/2024, the PASARR indicated the resident did not have a serious mental illness (such as . schizophrenia) and was not prescribed psychotropic medication. During an interview on 1/29/2025 at 12:30 p.m. with the Director of Nursing (DON), the DON stated the facility failed to accurately complete the PASARR level I screening for Residents 1 and 36 by indicating the residents did not have a severe mental illness and were not taking psychotropic medications despite being diagnosed with (and currently taking psychotropic medications for) schizophrenia. The DON stated Resident 1 and 36 both currently have schizophrenia which was clearly indicated in their clinical records. The DON stated, although these residents receive regular psychiatric care at the facility, an accurate PASARR was important to identify whether residents need special services based on mental illness. The DON stated Resident 1 and 36's inaccurate PASARR increased the risk that they may not have received needed specialized care based on their diagnoses possibly leading to a decline in their health and well-being. During a review of the facility policy and procedure (P&P) titled Antipsychotic Medication Use, dated March 2017, the P&P indicated .Residents who are admitted from the community or transferred from a hospital and who are already receiving antipsychotic medications will be evaluated for the appropriateness and indications for use. The interdisciplinary team will: Complete PASRR screening (preadmission screening for mentally ill and intellectually disabled individuals), if appropriate .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive care plan for 10 of 24 sampled residents (Residents 118, 48, 63, 60, 9, 75, 42, 71, 99, and 11), by failing to: 1. Develop a care plan to address Resident 118's elopement (the act of leaving a facility unsupervised and without prior authorization) from the facility on 10/13/2025. 2. Develop a care plan to address Resident 118, 48, 63, and 60's high risk for wandering (the act of roaming around and becoming lost or confused about their location) and elopement score. 3. Develop a care plan for Resident 9's use of temazepam (a medication to treat insomnia [difficulty falling asleep, staying asleep, or waking up too early, despite having adequate opportunity for sleep]). 4. Develop a care plan for Residents 75, 42, and 71's use of bed bars ([side rails]-a short rails on one or both sides of the bed that can be used to assist in bed mobility). 5. Ensure a fall mat (a floor pad designed to help prevent injury should a person fall) was placed at Resident 99's bedside, as indicated in Resident 99's fall risk care plan. 6. Ensure Resident 11 received a Magic Cup (a frozen dessert used for providing additional calories and protein to those experiencing involuntary weight loss) with meals, and a modified texture diet, as indicated in Resident 11's nutritional problem care plan. These deficient practices resulted in Resident 118 eloping from the facility, a second time, on 11/24/2024, and had the potential to result in Resident 48, 63, and 60 being under monitored and supervised for wandering and elopement. These deficient practices also resulted in the mismanagement of Resident 9's care with the use of Temazepam, which may increase Resident 9's risk of adverse effects (unwanted, uncomfortable or dangerous effects that a drug may have), and had the potential to negatively affect Residents 75, 42, 71, and 11's physical well-being and had the potential to result in injury. These deficient practices also resulted in Resident 11's decreased meal intake which could lead to weight loss, malnutrition and insufficient provision of care and services. Cross Reference F689 Findings: a. During a review of Resident 118's Admission Record (Face Sheet), the Face Sheet indicated Resident 118 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), psychoactive substance-induced persisting dementia (a deterioration of mental function resulting from the persisting effects of alcohol use), and altered mental status (a change in mental function, such as a decline in awareness, attention, or consciousness). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 118's Minimum Data Set ([MDS], a resident assessment tool), dated 10/3/2024, the MDS indicated Resident 118's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 118 required moderate assistance (helper does less than half the effort) with toileting, bathing, lower body dressing, and putting on and taking off footwear. The MDS indicated Resident 118 used a walker (a mobility aide that helps people walk by providing stability and balance) for mobility. During a review of Resident 118's Progress Note, dated 10/13/2024 and timed 4:45 p.m., the Progress Note indicated on 11/24/2024 at 3:30 p.m., Resident 118 was not in his room and was last seen on the smoking patio at 3 p.m. The Progress Note indicated Resident 118 did not have an out on pass order and staff checked within the facility and the surrounding areas. The Progress Note indicated Resident 118 was unable to be found. During a review of Resident 118's Progress Note, dated 11/24/2024 and timed at 7:24 p.m., the Progress Note indicated on 11/24/2024 at 3:35 p.m., Resident 118 was nowhere to be found within the facility. The Progress Note indicated Resident 118 stepped out of the facility unsupervised and undetected for the second time. The Progress Note indicated Resident 118's physician was made aware and instructed to report the incident to the police. During a review of Resident 118's Elopement and Wandering Risk Scale, dated 10/21/2024, the Elopement and Wandering Risk Scale indicated Resident 118 was at high risk to wander. During a concurrent interview and record review on 1/27/2025 at 2:13 p.m., with Registered Nurse (RN) 1, Resident 118's Care Plans, dated 10/13/2024 through 11/24/2024, were reviewed. The Care Plans did not indicate Resident 118's high risk for wandering and elopement score and Resident 118's first elopement on 10/13/2024 were addressed and care planned. RN 1 stated there should have been a care plan developed that addressed Resident 118's high risk for wandering and elopement and his first elopement on 10/13/2024. RN 1 stated care plans were developed as a template on who the resident was, their problems or risk factors, goals to be accomplished, and interventions the staff were to implement to provide care. RN 1 stated without the care plan addressing Resident 118's risk for elopement and actual elopement, the staff was unaware how to properly care for Resident 118. RN 1 stated without a plan to properly care for Resident 118's new behavior and actual elopement, Resident 118 was able to elope again on 11/24/2024 and had not returned to the facility. During an interview on 1/28/2025 at 11:11 a.m., with the MDS Coordinator (MDSC), the MDSC stated Resident 118 did not have a care plan that addressed the residents elopements on 10/13/2024 and 11/24/2024, nor his high risk for wandering and elopement. The MDSC stated those care plans were essential in promoting Resident 118's safety by directing the staff to implement interventions such as observing Resident 118's whereabouts frequently, utilizing a wander guard (a monitoring device) if necessary, redirecting Resident 118 if he were to be close to an exit, and utilize the social services department to frequently assess Resident 118's needs and concerns for leaving the facility. During an interview on 1/28/2025 at 2:52 p.m., with the Director of Nursing (DON), the DON stated the type, the frequency, and the person responsible of the monitoring for a high risk for wandering and elopement resident would be indicated on the care plan and physician's order. The DON stated without a care plan with specific interventions, Resident 118 would not receive the necessary care and monitoring to prevent Resident 118 from eloping from the facility. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 63's Face Sheet, the Face Sheet indicated Resident 63 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included heart failure (occurs when the heart cannot pump enough blood and oxygen to the body), dementia (a progressive state of decline in mental abilities), and encephalopathy (brain damage that affects how the brain functions). During a review of Resident 63's MDS, dated [DATE], the MDS indicated Resident 63's decision-making skills were moderately impaired. The MDS indicated Resident 63 was dependent on staff's assistance with oral hygiene, toileting, bathing, and personal hygiene. The MDS indicated Resident 63 used a wheelchair for mobility. During a review of Resident 63's History and Physical (H&P), dated 5/31/2024, the H&P indicated Resident 63 had the capacity to understand and make decisions. During a review of Resident 63's Elopement and Wandering Risk Scale, dated 12/28/2024, the Elopement and Wandering Risk Scale indicated Resident 63 was at high risk to wander. During a concurrent interview and record review on 1/29/2025 at 3:16 p.m., with the MDSC, Resident 63's Care Plans, dated 3/19/2021 through 1/29/2025, were reviewed. The care plans did not indicate Resident 63's high risk for wandering and elopement score were addressed and care planned. The MDSC stated Resident 63 was dependent on staff's assistance with his mobility, therefore, did not create a care plan for his high risk for wander. The MDSC stated a care plan should have been created to guide the staff on how to care for Resident 63. c. During a review of Resident 48's Face Sheet, the Face Sheet indicated Resident 48 was admitted to the facility on [DATE] with diagnoses that included traumatic brain injury (a brain injury caused by an external force, such as a blow to the head), traumatic subarachnoid hemorrhage (a life-threatening brain bleed that occurs when blood vessels in the brain are damaged by trauma), and fracture of the right tibia (a break in the shinbone on the right leg). During a review of Resident 48's MDS, dated [DATE], the MDS indicated Resident 48's decisions-making skills were moderately impaired. The MDS indicated Resident 48 was dependent on staff's assistance with oral hygiene, toileting, bathing, dressing, and personal hygiene. During a review of Resident 48's H&P, dated 9/14/2024, the H&P indicated Resident 48 had the capacity to understand and make decisions. During a review of Resident 48's Elopement and Wandering Risk Scale, dated 12/28/2024, the Elopement and Wandering Risk indicated Resident 48 was at high risk to wander. During a concurrent interview and record review on 1/29/2025 at 3:19 p.m., with the MDSC, Resident 48's Care Plans, dated 9/12/2024 through 1/29/2025, were reviewed. The care plans did not indicate Resident 48's high risk for wandering and elopement score were addressed and care planned. The MDSC stated Resident 48 was bed-bound and did not ambulate (walk), therefore, a care plan for the resident's high risk for wandering and elopement was not created. The MDSC stated Resident 48's high risk for wandering and elopement should have been care planned to create and implement interventions to keep Resident 48 safe. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. During a review of Resident 60's Face Sheet, the Face Sheet indicated Resident 60 was admitted to the facility on [DATE] with diagnoses that included multiple sclerosis (a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord), schizophrenia (a mental illness that is characterized by disturbances in thought), and chronic kidney disease (when the kidneys are damaged and cannot filter blood the way they should). During a review of Resident 60's MDS, dated [DATE], the MDS indicated Resident 60's cognition was severely impaired. The MDS indicated Resident 60 required maximal assistance (helper does more than half the effort) with toileting, bathing, and lower body dressing. The MDS indicated Resident 60 used a cane for mobility. During a review of Resident 60's H&P, dated 10/20/2024, the H&P indicated Resident 60 had fluctuating capacity to understand and make decisions. During a review of Resident 60's Elopement and Wandering Risk Scale, dated 10/30/2024, the Elopement and Wandering Risk Scale indicated Resident 60 was at high risk to wander. During a concurrent interview and record review on 1/30/2025 at 11:22 a.m., with the MDSC, Resident 48's Care Plan for Resident 48's high risk for elopement and wandering, dated 1/29/2025, was reviewed. The care plan indicated Resident 48 was a high risk for elopement and wandering. The staff interventions indicated to add a blue identifier sticker to Resident 48's wristband and room door, monitor and document wandering behavior every shift, and observe Resident 48's whereabouts every shift. The MDSC stated Resident 48 should have had a care plan to address her high risk of wandering immediately after her Elopement and Wandering Risk Scale was completed. The MDSC stated without a care plan to communicate to the staff of the resident's high risk for wandering and elopement, the staff may not be aware of specific behaviors to look for and the resident could elope from the facility. e. During a review of Resident 9's Face Sheet, the Face Sheet indicated Resident 9 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included schizophrenia, anxiety disorder (a mental health condition characterized by excessive and persistent worry, fear, and unease that can interfere with daily life), and encephalopathy. During a review of Resident 9's MDS, dated [DATE], the MDS indicated Resident 9's cognition was moderately impaired. The MDS indicated Resident 9 required maximal assistance with toileting, bathing, lower body dressing, and personal hygiene. During a review of Resident 9's H&P, dated 9/25/2024, the H&P indicated Resident 9 had the capacity to understand and make decisions. During a review of Resident 9's Order Recap Report, dated 6/1/2024 through 1/29/2025, the Order Recap Report indicated to administer Temazepam 15 milligrams (mg, unit of measurement), by mouth, at bedtime for Resident 9's inability to sleep. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/30/2025 at 11:23 am., with the MDSC, Resident 9's Care Plans, dated 2/17/2021 through 1/30/2025, were reviewed. The care plans did not indicate Resident 9's use of temazepam was addressed and care planned. The MDSC stated Resident 9 was on a scheduled sleeping-aide medication and should have been care planned to ensure Resident 9 was being monitored for the hours of sleep acquired every night so the nursing staff could communicate to Resident 9's physician the efficacy of the Temazepam. The MDSC stated the care plan would guide the nurses to monitor for any side effects, to discourage napping throughout the day, and to be aware of the black box [NAME] (a label on a drug that alerts the healthcare providers to a serious risk of injury or death by administering the drug). The MDSC stated without the appropriate care plans in place, Resident 9 was at risk of not receiving the necessary care and services. 47286 f. During a review of Resident 75's Face Sheet, the Face Sheet indicated Resident 75 was admitted to the facility on [DATE] with diagnoses included dysphagia (difficulty swallowing), muscle weakness (loss of muscle strength), and hypertension ([HTN]- high blood pressure. During a review of Resident 75's MDS, dated [DATE], the MDS indicated Resident 75's cognitive skills for daily decision making was intact. The MDS indicated Resident 75 was independent with eating, toileting hygiene, and upper body dressing. The MDS indicated Resident 75 required moderate (helper does less than half the effort) assistance from staff for showering/bathing. During a concurrent observation and interview on 1/27/2025 at 9:23 a.m., with Resident 75, in Resident 75's room, Resident 75 was observed lying in the bed. Resident 75's bed had quarter side rails on the left and right side of the bed. Resident 75 stated he used the side rails to assist with moving in and out of the bed. During a concurrent interview and record review on 1/30/2025 at 12:05 p.m., with the Director of Nursing (DON), Resident 75's active care plans were reviewed. The DON stated Resident 75's care plans did not indicate Resident 75 used side rails as a bed mobility. The DON stated Resident 75 did not have a care plan developed that indicated the resident's use of bed rails and/or monitored Resident 75's safety for the bed rail use. g. During a review of Resident 42's Face Sheet, the Face Sheet indicated Resident 42 Resident 42 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), muscle weakness, and dysphagia. During a review of Resident 42's MDS, dated [DATE], the MDS indicated Resident 42's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 42 required moderate assistance from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 1/27/2025 at 10:17 a.m., with Certified Nursing Assistant (CNA 4), in Resident 42's room, CNA 4 stated Resident 42 was observed lying in bed and had quarter side rails on the left and right side of the bed. CNA 4 stated Resident 42 had bilateral side rails on her bed to enable her functional mobility. During a concurrent interview and record review on 1/30/2025 at 12:15 p.m., with the DON, Resident 42's active care plans were reviewed. The DON stated there was no care plan developed for Resident 42's safety and side rail needs. h. During a review of Resident 71's Face Sheet, the Face Sheet indicated Resident 71 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia and hemiparesis (total paralysis of the arm, leg, and trunk on the same side of the body), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and HTN. During a review of Resident 71's MDS, dated [DATE], the MDS indicated Resident 71's cognitive skills for daily decision making was intact. The MDS indicated Resident 71 required moderate assistance from staff for ADLs. During a concurrent observation and interview on 1/27/2025 at 11:55 a.m., with Resident 71, in Resident 71's room, Resident 71 was observed sitting on the bed. There were quarter side rails on both sides of the bed. Resident 71 stated he used the side rails for bed mobility. During an interview on 1/30/2025 at 11:55 a.m., with the Director of Nursing (DON), the DON stated when side rails were used as an enabler (assistive device to aid mobility), the residents should have a care plan developed. During a concurrent interview and record review on 1/30/2025 at 12:30 p.m., with the DON, Resident 71's active care plans were reviewed. The DON stated he was not able to locate a care plan for Resident 71's safety, side rail use, and needs. The DON stated Resident 71's side rails were used for assistance with bed mobility and a care plan should have been developed. The DON stated the care plan would indicate the reason for the side rails, the individualized goals, and interventions to be implemented. During an interview on 1/30/2025 at 12:45 p.m., with the DON, the DON stated care plan serves as a communication tool among facility staff who provided care for the residents. The DON stated without care plan interventions on the residents' side rails use, the nursing staff would not have guidance on how to properly care and monitor the residents' safety. 48343 i. During a review of Resident 99's Admission Record, the Admission Record indicated Resident 99 was originally admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 99's admitting diagnoses included generalized muscle weakness and repeated falls. During a review of Resident 99's H&P, dated 5/18/2024, the H&P indicated Resident 99 had the capacity to understand and make decisions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 99's MDS, dated [DATE], the MDS indicated Resident 99 did not have any cognitive impairment. The MDS indicated Resident 99 had bilateral lower extremity (legs) impairments and was dependent on staff for assistance with ADLs. The MDS indicated Resident 99's ability to transfer between surfaces (bed to chair, chair to toilet, etc.) and ability to transition between lying and sitting or sitting and standing positions was not attempted due to his medical conditions or safety concerns. The MDS indicated Resident 99 did not exhibit rejection of care, including refusal of assistance with ADLs. During a review of Resident 99's care plan titled At risk for unavoidable fall related to balance problem . generalized weakness, history of repeated falls ., dated 5/28/2024, the care plan indicated the staff interventions were to place a floor mat to the right side of Resident 99's bed. During an observation on 1/27/2025 at 9:40 a.m., at Resident 99's bedside, no fall mat was observed to the right side of Resident 99's bed. During an observation on 1/27/2025 at 12:52 p.m., at Resident 99's bedside, no fall mat was observed to the right side of Resident 99's bed. During a concurrent interview and observation on 1/28/2025 at 10:07 a.m., at Resident 99's bedside, no fall mat was observed to the right side of Resident 99's bed. Resident 99 stated he fell two or three times (dates unknown). Resident 99 stated he was trying to get out of bed alone and fell . During an observation on 1/29/2025 at 9:11 a.m., at Resident 99's bedside, no fall mat was observed to the right side of Resident 99's bed. During a concurrent observation and interview on 1/29/2025 at 10:14 a.m., at Resident 99's bedside with Licensed Vocational Nurse (LVN) 3, LVN 3 stated Resident 99 did not have a fall mat to the right side of his bed. LVN 3 stated she provided care to Resident 99 for the last two months and had not seen a fall mat at Resident 99's bedside during those two months. During an interview on 1/30/2025 at 10:00 a.m., with RN 1, RN 1 stated fall mats were provided to minimize and/or prevent injury related to falls. RN 1 stated that the absence of a fall mat could result in the resident sustaining avoidable injury from fall. During an observation on 1/30/2025 at 12:00 p.m., at Resident 99's bedside, no fall mat was observed to the right side of Resident 99's bed. j. During a review of Resident 11's Admission Record, the Admission Record indicated Resident 11 was originally admitted on [DATE] and was most recently readmitted on [DATE]. Resident 11's admitting diagnoses included metabolic encephalopathy (a problem in the brain caused by chemical imbalances in the blood), DM, and dysphagia. During a review of Resident 11's MDS, dated [DATE], the MDS indicated Resident 11 had severe cognitive impairment. The MDS indicated Resident 11 could eat independently once a meal was placed in front of him. The MDS indicated Resident 11 required supervision or touch assistance from staff for mobility while in and out of bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 11's diet order, dated 6/27/2024, the diet order indicated Resident 11 was to have a Magic Cup three times a day with meals. The order also indicated Resident 11 was to receive a mechanical soft, finely chopped diet (a texture-modified diet that includes finely chopped foods, used for individuals who have difficulty chewing or swallowing). During a review of Resident 11's care plan titled Nutritional problem or potential nutritional problem ., dated 12/22/2021, the care plan indicated the goals were for Resident 11 to achieve a goal weight of 177 pounds. The care plan interventions indicated staff were to provide Resident 11's diet as ordered. During a concurrent observation and interview, on 1/27/2025 at 9:29 a.m., with CNA 1, Resident 11's breakfast tray and tray ticket (a slip of paper that displays exactly what that resident will be receiving, based on the resident's diet order and food preferences) were observed. CNA 1 stated Resident 11's tray ticket indicated Resident 11 was to receive a Magic Cup and a mechanical soft, finely chopped texture. CNA 1 stated Resident 11's breakfast tray did not contain a Magic Cup, and stated Resident 11's eggs were not finely chopped. During an observation on 1/27/2025 at 1:36 p.m., of Resident 11's lunch tray and tray ticket, the tray ticket indicated Resident 11 was to be provided a Magic Cup. No magic cup was observed on the tray. During an observation on 1/28/2025 at 1:37 p.m., of Resident 11's lunch tray and tray ticket, the tray ticket indicated Resident 11 was to be provided a Magic Cup and a mechanical soft, finely chopped meal. No magic cup was observed on the tray, and Resident 11's dessert was not finely chopped. During a review of the facility's policy and procedure (P&P) titled, Wandering, Unsafe Resident, revised 8/2014, the P&P indicated, The resident's care plan will indicate the resident is at risk for elopement or other safety issues. Interventions to try to maintain safety, such as a detailed monitoring plan will be included. During a review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered', revised 12/2016, the P&P indicated facility would develop and implement a person-centered care plan for each resident. The P&P indicated person-centered care plan would include measurable objectives to meet the resident's physical, psychosocial, and functional needs. During a review of the facility's P&P titled Proper Use of Side Rails, revised 12/2016, the P&P indicated facility would ensure safe use of side rails as resident mobility aids. The P&P indicated the use of side rails as an assistive device would be addressed in the resident care plan.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on interview and record review, the facility failed to ensure Certified Nursing Assistant (CNA) 7 and CNA 8 accurately documented the percentage of meals eaten for one of five sampled residents (Resident 1). This deficient practice created the potential for licensed nursing staff, the dietician, and the dietary supervisor to be unaware of Resident 1's actual meal intakes, and result in Resident 1 sustaining undetected malnutrition and weight loss. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted on [DATE]. Resident 1's admitting diagnoses included generalized muscle weakness, dysphagia (difficulty swallowing), and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 11/25/2024, the MDS indicated Resident 1 did not have cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 1 was independent to eat once a meal was placed in front of him. During a review of Resident 1's Record of Amount of Food Eaten, dated 1/17/2025 to 1/29/2025, the record indicated CNA 7 documented on 1/27/2025 at 1:02 p.m. that Resident 1 consumed 60 percent (%) of his lunch tray. During a review of Resident 1's Record of Amount of Food Eaten, dated 1/17/2025 to 1/29/2025, the record indicated CNA 8 documented, on 1/28/2025 at 12:57 p.m., that Resident 1 consumed 70% of his lunch tray. During a concurrent observation and interview on 1/27/2025 at 1:14 p.m., at Resident 1's bedside, Resident 1's lunch tray was observed on his bedside table. Resident 1's lunch tray had two chicken drumsticks, a side of mashed potatoes, and a side of diced carrots. Resident 1 stated he did not eat meat and stated he would not be eating any food on the tray. Resident 1 stated none of the food delivered on his lunch tray had been consumed. During a concurrent observation and interview on 1/28/2025 at 1:01 p.m., at Resident 1's bedside, Resident 1's lunch tray was observed on his bedside table. Resident 1's lunch tray included two scoops of chicken, two scoops of beans and rice, and a biscuit. Resident 1 stated he was not going to eat the food on the tray and stated none of the food delivered on his lunch tray had been consumed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation, interview, and record review, on 1/28/2025 at 1:28 p.m., with CNA 8, Resident 1's record of amount of eaten, dated 1/17/2025 to 1/29/2025 was reviewed. Resident 1's lunch tray was observed. CNA 8 stated the record indicated Resident 1 consumed 70% of his lunch tray. CNA 8 stated Resident 1 did not eat any food from his lunch tray. CNA 8 stated the documentation of how much food was eaten was supposed to be accurate, and stated she should not have documented that Resident 1 consumed 70% of his meal. CNA 8 stated the licensed nurse was to be notified whenever a resident consumed less than 50% of their meal, and stated she notified Licensed Vocational Nurse (LVN) 1 of Resident 1's meal intake of less than 50%. During an interview on 1/28/2025 at 1:32 p.m., with LVN 1, LVN 1 stated Resident 1's meal intake of 50% or less was not reported to her by CNA 8. LVN 1 stated that it was important to know about decreased meal intake because it could indicate the resident had an acute illness or could indicate a failure to thrive (decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). During an interview on 1/30/2025 at 12:31 p.m., with the Dietary Supervisor (DS), the DS stated he did quarterly nutritional assessments of the facility residents, including an assessment of the residents' usual meal intakes. The DS stated that the residents' usual intakes are based on the percentages documented by the CNAs. The DS stated that usual meal intakes below 75% were considered low. The DS stated this low percentage of meal intake would prompt him and the Registered Dietician to meet with the resident to determine the cause of the low intake. During an interview on 1/30/2025 at 12:33 p.m., with the Director of Staff Development (DSD), the DSD stated CNAs were trained to alert the charge nurse when a resident consumed 50% or less of any meal. The DSD stated the percentage of meal eaten was to be documented after the tray was collected and should be accurate. The DSD stated the importance of accurate CNA charting was to prevent weight loss and malnutrition. The DSD stated the percentage of meals eaten was also referenced by the Registered Dietician to guide the plan of care. The DSD stated that if the documentation was not accurate, the resident could sustain potential malnutrition. During a review of the facility's policy and procedure (P&P) titled Charting and Documentation, revised 4/2018, the P&P indicated all observations were to be documented in the resident's clinical records. During a review of the facility's job description for CNAs, dated 2023, the job description indicated CNAs were to record resident's food and fluid intake, and report changes in the resident's eating habits.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on observation, interview, and record review, the facility failed to ensure the settings on the low-air-loss mattress (LALM, an air mattress designed to help prevent and treat pressure ulcers [localized damage to the skin and/or underlying tissue usually over a bony prominence]) were correct for one of one sampled resident (Resident 99). This deficient practice placed Resident 99 at risk for a worsened condition of his existing pressure ulcer and/or the development of new pressure ulcers. Findings: During a review of Resident 99's Admission Record, the Admission Record indicated Resident 99 was originally admitted on [DATE] and was most recently readmitted on [DATE]. Resident 99's admitting diagnoses included generalized muscle weakness and adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 99's Minimum Data Set (MDS, a resident assessment tool), dated 11/26/2024, the MDS indicated Resident 99 did not have cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 99 required partial to moderate assistance from staff to roll from left to right while in bed and indicated Resident 99's ability to transfer between surfaces (bed to chair, chair to toilet, etc.) and ability to transition between lying and sitting or sitting and standing positions was not attempted due to his medical conditions and/or safety concerns. During a review of Resident 99's physician order, dated 8/21/2024, the order indicated Resident 99 was to have a LALM for wound management. During a review of Resident 99's care plan titled [Resident] has actual impairment to skin integrity . sacrococcyx (tailbone region) Stage 3 [pressure ulcer] (full-thickness loss of skin, dead and black tissue may be visible), dated 5/28/2024, the care plan indicated goals of care were to be free from further skin breakdown. The care plan interventions included use of a LALM. During an observation on 1/27/2025 at 12:50 p.m., at Resident 99's bedside, Resident 99's LALM was observed as set at 150 pounds (lbs., a unit of measuring weight). During an observation on 1/28/2025 at 1:08 p.m., at Resident 99's bedside, Resident 99's LALM was observed as set at 150 lbs. During an observation on 1/29/2025 9:52 a.m., at Resident 99's bedside, Resident 99's LALM was observed as set at 150 lbs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 1/29/2025 at 9:58 a.m., with the Treatment Nurse (TN), Resident 99's current body weight was reviewed. The TN stated Resident 99's current weight was 118 lbs, and stated Resident 99 had not weighed 150 lbs. or more in the last 6 months. The TN stated LALMs were used to prevent development of pressure ulcers or prevent worsening of existing pressure ulcers. The TN stated LALM settings were only to be adjusted by the TN and stated the settings were based on the resident's weight. The TN stated that the higher the weight setting, the firmer the mattress. The TN stated a firmer mattress added more pressure to bony prominences and could worsen existing pressure ulcers or cause new pressure ulcers to develop. During a concurrent observation and interview on 1/29/2025 at 10:05 a.m., with the TN, at Resident 99's bedside, Resident 99's LALM was observed. The TN stated Resident 99's LALM settings were for a resident weighing 150 lbs., and stated this setting was too high for Resident 99 and was not correct. The TN stated Resident 99's LALM settings should have been lower. During a review of the operator's manual for the Med-Aire Melody Low Air Loss and Alternating Pressure Mattress Replacement System, dated 3/2019, the operator's manual indicated there was a Pressure Adjust Knob which was to be adjusted to the required pressure level, with patient weight settings available on the knob perimeter as a guide.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Villa Care Center	12029 Avalon Blvd Los Angeles, CA 90061

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on interview and record review the facility failed to ensure five of eight sampled residents (Resident 118, 319, 55, 99, and 117) were free of accidents and hazards by failing to: 1. Follow its policy and procedure (P&P) titled, Wandering, Unsafe Resident, which indicated the facility would identify residents at risk for harm due to unsafe wandering and elopement by failing to ensure: a. Resident 118, who was assessed as high risk for wandering (the act of roaming around and becoming lost or confused about their location) and elopement (the act of leaving a facility unsupervised and without prior authorization), did not elope from the facility on 10/13/2024 and 11/24/2024 (42 days after the first elopement). b. Staff were aware of all residents at risk for wandering and elopement. c. Staff were aware of Resident 118's high risk for elopement and how to prevent Resident 118 from leaving the facility unnoticed. d. A person-centered care plan (document that helps nurses and other team care members organize aspects of resident care) with measurable interventions was created for Resident 118, after Resident 118 eloped from the facility on 10/13/2024, to prevent Resident 118 from eloping again on 11/24/2024. e. A readmission 72-Hour Monitoring was conducted for Resident 118 after he eloped and was readmitted on [DATE], to ensure Resident 118 did not have exit seeking behaviors. f. Resident 118 was not placed in a room near the lobby exit door, after he eloped on 10/13/2024 and was readmitted to the facility. g. An interdisciplinary care team ([IDT], a group of different disciplines working together towards a common goal for a resident) meeting was conducted to address Resident 118's elopement on 10/13/2024, to prevent further elopements. h. Staff were in-serviced (a professional training on a particular subject) on how to care for residents at risk for wandering and elopement. i. The P&P titled, Safety and Supervision of Residents, was followed, which indicated each resident's risk factors were identified and interventions adjusted accordingly to meet the resident's individual needs. 2. Notify the State Agency (SA) on 11/9/2024, following an incident of Resident 117 trespassing on the facility premises with a large knife. 3. Ensure Resident 319's and 55's lighters were securely stored and inaccessible to facility residents identified as unsafe to independently use or keep a lighter in their possession. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. Ensure a fall mat (a floor pad designed to help prevent injury should a person fall) was placed at Resident 99's bedside. As a result, on 11/24/2024, Resident 118 eloped from the facility and as of 01/29/2025 (66 days later), Resident 118 has not been found. There is a likelihood for Resident 118 to suffer medical complications such as malnutrition, dehydration, stroke, exposure to harsh environmental conditions including excessive cold, fire, possible motor vehicle accident, and and/or possible death. These deficient practices also placed all facility residents at risk for avoidable physical and psychosocial harm related to the presence of a resident trespassing onto facility premises with a large knife, and potential burn-related injuries from unsupervised use of lighters. These deficient practices also placed Resident 99 at risk for physical injury from a fall. On 1/29/2025 at 12:35 p.m., an Immediate Jeopardy ([IJ], a situation in which the facility's noncompliance with one or more requirements of participation had cause, or was likely to cause serious injury, harm, impairment, or death to a resident) was called in the presence of the Administrator (ADM) due to the facility's failure to monitor Resident 118, create a care plan, and conduct an IDT meeting after Resident 118 eloped on 10/13/2024 and to prevent Resident 118's elopement from the facility on 11/24/2024. On 1/31/2025 at 2:11 p.m., the facility submitted an acceptable IJ Removal Plan (IJRP). After onsite verification of the IJRP implementation through observation, interview, and record review, the IJ was removed onsite at 1/31/2025 at 3:01 p.m., in the presence of the ADM. The IJRP included the following immediate actions: 1. A facility-wide assessment was conducted on 1/30/2025 by the Director of Nursing (DON), Director of Staff Development (DSD), Minimum Data Set Nurse (MDSN), and the Quality Assurance (QA) Nurse to reevaluate all in-house residents. The Medical Records Director (MRD) conducted an audit to identify other residents who were at high risk for elopement. Three residents (Residents 48, 60, and 63) were identified at high risk for elopement. 2. An IDT meeting was conducted for Residents 48, 60, and 63 to address their high risk for elopement score. 3. Residents 48, 60, and 63's care plans were updated by the DON to address their elopement and wandering risk with goals and interventions. The interventions included: a. Add a blue identifier sticker to the resident's wrist band and room door to alert staff or resident being high risk for wandering and elopement. b. The completion of the elopement/wandering assessment to be completed upon admission, quarterly, and as needed. c. Monitor wandering behavior and document in the electronic health record (eHR) in the behavior monitoring tab by the licensed nurse every shift and as needed. d. Observe for any change in condition that may indicate risk for elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	e. Observe whereabouts of resident each shift. Elopement behavior documented in the eHR every shift and the certified nursing assistants (CNAs) would complete the Behavior Monitoring log and provide to the Medical Records daily for compliance. 4. The ADM, DON, and DSD developed a visual aide and process to assist in clearly identifying all residents who were high risk for elopement and is routinely accessed by staff. The color blue was adopted as an elopement risk identifier. After a resident was identified to be a high risk for elopement, a blue sticker would be applied to the resident's wrist band and to the resident's door tag. A blue page was added in the Change of Condition (COC) binder at each nurses' station and would have the residents' information and brought to the attention of the nursing staff during daily shift change huddles. Additional blue binders were added in the Activity, Dietary, and Laundry/Housekeeping departments and would be reviewed and/or updated at least daily by the DON and/or the registered nurse (RN). 5. The ADM updated the facility P&P titled, Safety and Supervision of Residents to include executing and implementing interventions identifiers. The ADM updated the P&P titled, Wandering, Unsafe Resident to include: a. An IDT would be arranged within two days to address the resident's wandering and elopement behavior and/or those whose assessments indicated high risk for elopement. b. Staff would apply a blue sticker to the resident's wrist band and door tag. c. Staff would include the resident's information to the Elopement section of the COC binder located at each nurse's station. d. Staff would open a behavior monitoring specific for episodes of wandering in the Medication Administration Record (MAR). e. CNAs would complete the Behavior Monitoring log to conduct hourly monitoring, and provide to the Medical Records daily for compliance. f. Staff would update resident's care plan to include the behavior or unsafe wandering and elopement, and their high risk for elopement. g. An IDT would be conducted when a resident elopes and returns to the facility, to assess the resident's behavior. 6. The ADM conducted an immediate Quality Assurance Meeting (QA) on 1/30/2025 to include a report that outlined the updated P&Ps titled, Safety and Supervision of Residents and Wandering, Unsafe Resident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. The DON and DSD started an immediate in-service, on 1/29/2025, with all staff regarding the updated P&Ps titled, Safety and Supervision of Residents and Wandering, Unsafe Resident, how to provide safety and supervision to residents, identification of residents who were high risk for elopement, unsafe wandering behavior, color code identifying elopement risk residents, and the location of COC and department binders. The facility will complete 100% staff in-service by 2/5/2025. Those staff who are out of the facility and not able to attend the in-services would be in-serviced upon their return to the facility. 8. The DSD would provide initial education during the employee's on-boarding orientation, thereafter the DSD and/or the DON would provide the continued in-serviced to all facility staff at least quarterly and as needed (when the facility experienced a close call or when additional in-service was needed for retraining needs). The in-service education would focus on wandering and elopement, providing safety and supervision to residents, identification of residents who were high risk for elopement, unsafe wandering behaviors, color code identification, and location of COC and department binders. 9. Upon completion of any resident's IDT or COC, where the outcome results in the resident being at risk for elopement, the DON, DSD, or ADM would assess the resident's room assignment. If the resident's room was within approximately 30 feet (ft, unit of measurement) of any exit, the DON, DSD, and/or the ADM would review the Occupational Therapy Summary to assess the resident's physician abilities to see if they had the potential to successfully elope. Findings: 1. During a review of Resident 118's Admission Record (Face Sheet), the Face Sheet indicated Resident 118 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), psychoactive substance-induced persisting dementia (a deterioration of mental function resulting from the persisting effects of alcohol use), and altered mental status (a change in mental function, such as a decline in awareness, attention, or consciousness). During a review of Resident 118's Minimum Data Set ([MDS], a resident assessment tool), dated 10/3/2024, the MDS indicated Resident 118's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 118 normally used a walker (a mobility aide that helps people walk by providing stability and balance). The MDS indicated Resident 118 required moderate assistance (helper does less than half the effort) with toileting, bathing, lower body dressing, and putting on and taking off footwear. a. During a review of Resident 118's Progress Note, dated 11/24/2024 and timed at 7:24 p.m., the Progress Note indicated on 11/24/2024 at 3:35 p.m., Resident 118 was nowhere to be found within the facility. The Progress Note indicated Resident 118 stepped out of the facility unsupervised and undetected [for] the second time. The Progress Note indicated staff make thorough search inside and outside the facility. The Progress Note indicated Resident 118's physician was made aware and instructed to report the incident to the police. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a concurrent interview and record review on 1/27/2025 at 2:07 p.m., with Registered Nurse (RN) 1, Resident 118's Elopement and Wandering Risk Scale, dated 10/21/2024, was reviewed. The Elopement and Wandering Risk Scale indicated Resident 118 was a high risk to wander. RN 1 stated when a resident was determined to be a high risk for wandering and elopement, additional interventions must be put into place to promote safety for the resident. RN 1 stated once Resident 118 was assessed as high risk for wandering and elopement, immediately the facility should have initiated a plan to put extra set of eyes on him, educate the staff of Resident 118's wandering and elopement score, updated his care plan, and conducted a room change to prevent Resident 118's second elopement on 11/24/2024. b. During an interview on 1/27/2025 at 2:10 p.m., with RN 1, RN 1 stated the facility did not have a way to easily identify residents who were at high risk for wandering and elopement. RN 1 stated the licensed nurses conducted the change-of-shift huddle (a brief meeting where nurses would discuss patient care, safety, and workload) to discuss the residents' needs within their assigned area. RN 1 stated the facility was divided into four stations and within each station and the individual change-of-shift huddles would not incorporate any resident information outside of the station. RN 1 stated when a resident was assessed as high risk for elopement, the CNAs would be instructed verbally to keep an eye on them. During an interview on 1/28/2025 at 12:26 p.m., with RN 2, RN 2 stated during change-of-shift huddle, they do not communicate any high risk for elopement residents in other stations and only focus on the residents within their station. During an interview on 1/28/2025 at 2:52 p.m., with the Director of Nursing (DON), the DON stated once a resident was assessed as high risk for wandering and elopement, that individual information would be included in the change-of-shift huddle for the station they resided in. The DON stated if a resident who was high risk for wandering and elopement ambulated to a different station, the nurses would not be aware of the resident's status. The DON stated the staff had access to an electronic communication tool, where residents at risk for wandering and wandering could be posted, however, the posted communication would move down the board and eventually disappear, unless the information was moved forward. c. During an interview on 1/27/2025 at 2:10 p.m., with RN 1, RN 1 stated Resident 118's risk for wandering and elopement was only communicated to the nurses and CNAs within East Station and would not be communicated to the other three stations. RN 1 stated Resident 118 was ambulatory (able to walk) and if Resident 118 walked to a different station, the staff would not know Resident 118 required close supervision to prevent wandering and elopement. During an interview on 1/27/2025 at 3:40 p.m., with Certified Nursing Assistant (CNA) 2, CNA 2 stated she was assigned to Resident 118 on 11/24/2024 and last saw him at 3:30 p.m. in the dining room. CNA 2 stated during change-of-shift huddle, she would be instructed to just keep an eye on [Resident 118], however, there was no direction on how often to indicate Resident 118's whereabouts and there was nowhere to document their observations. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/28/2025 at 10:32 a.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 118 was very sneaky and was able to elope from the facility two times. LVN 2 stated Resident 118 was ambulatory with a walker and would walk around the facility LVN 2 stated during his rounds on 11/24/2024 at 3:35 p.m., he realized Resident 118 was nowhere to be found. LVN 2 stated he was unsure how Resident 118 eloped from the facility. LVN 2 stated Resident 118 required close supervision and when an extra CNA was available, the CNA would be assigned to Resident 118 to closely monitor and supervise him through the shift. LVN 2 stated this type of close monitoring would not always be possible and the RN on duty would take it upon herself to have Resident 118 sit with her in the nurse's station during the shift to ensure Resident 118's whereabouts. LVN 2 stated they did not have a documented plan of care to address Resident 119's behaviors, however, the nurses and CNAs would be verbally instructed to monitor him closely. During an interview on 1/29/2025 at 9:10 a.m., with LVN 1, LVN 1 stated the CNAs were verbally instructed to do frequent visual checks on the residents that required close monitoring. LVN 1 stated she did not document any visual checks, Resident 118's whereabouts, nor any redirection interventions for Resident 118. LVN 1 stated she was only aware of the residents in her station and did not know about any other high risk for wandering and elopement in the other stations. During an interview on 1/29/2025 at 2:49 p.m., with CNA 2, CNA 2 stated when a resident required monitoring for a behavior or change of condition, the nurses would initiate a Stop and Watch form where the nurses and CNAs would document on. CNA 2 stated Resident 118 did not have a Stop and Watch form, nor any other required documentation specific to his monitoring and supervision. d. During a concurrent interview and record review on 1/27/2025 at 2:13 p.m., with RN 1, Resident 118's Care Plans were reviewed. The Care Plans did not indicate Resident 118's high risk for wandering and elopement score and Resident 118's first elopement on 10/13/2024 were addressed and care planned. RN 1 stated there should have been a Care Plan developed that addressed Resident 118's high risk for wandering and elopement and his first elopement on 10/13/2024. RN 1 stated Care Plans were developed as a template on who the resident was, their problems or risk factors, goals to be accomplished, and interventions the staff were to implement to provide care. RN 1 stated without the Care Plans addressing Resident 118's risk for elopement and actual elopement, the staff was unaware how to properly care for Resident 118. RN 1 stated without a plan to properly care for Resident 118's new behavior and actual elopement, Resident 118 was able to elope again on 11/24/2024 and had not returned to the facility. During an interview on 1/28/2025 at 11:11 a.m., with the Minimum Data Set Coordinator (MDSC), the MDSC stated Resident 118 did not have a care plan that addressed his elopements on 10/13/2024 and 11/24/2024, nor his high risk for wandering and elopement. The MDSC stated those care plans were essential in promoting Resident 118's safety by directing the staff to implement interventions such as observing Resident 118's whereabouts frequently, utilizing a wander guard (a monitoring device), if necessary, redirecting Resident 118 if he were to be close to an exit, and utilize the social services department to frequently assess Resident 118's needs and concerns for leaving the facility. During an interview on 1/28/2025 at 2:52 p.m., with the DON, the DON stated the type, the frequency, and the person responsible of the monitoring for a high risk for wandering and elopement resident would be indicated on the Care Plan and physician's order. The DON stated without a care plan with specific interventions, Resident 118 would not receive the necessary care and monitoring to prevent Resident 118 from eloping from the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	e. During a concurrent interview and record review on 1/27/2025 at 2:16 p.m., with RN 1, Resident 118's Progress Notes were reviewed. The Progress Notes did not indicate Resident 118 was monitored when readmitted to the facility on [DATE]. RN 1 stated the licensed nurses did not perform and did not document a 72-Hour Monitoring for Resident 118, after the resident eloped on 10/13/2024. RN 1 stated it was important to conduct the 72 Hour monitoring to assess the resident's adjustment to the facility and other behaviors such as exit-seeking. During an interview on 1/28/2025 at 2:52 p.m., with the DON, the DON stated the 72-Hour Monitoring when a resident was admitted to the facility was important to see how the resident was adjusting to the facility and if there were any concerns that needed to be addressed. f. During an interview on 1/27/2025 at 1:44 p.m., with RN 1, RN 1 stated Resident 118 was readmitted on [DATE] and was placed in a room near the lobby exit. RN 1 stated Resident 118's room placement was inappropriate because Resident 118 might have eloped the second time on 11/24/2024, through the lobby exit door. RN 1 stated Resident 118 should have been placed in a room closer to the nurse's station so Resident 118 could be easily monitored more closely. RN 1 stated she did not know how Resident 118 eloped on 10/13/2024. During an interview on 1/28/2025 at 12:26 p.m., with RN 2, RN 2 stated she readmitted Resident 118 to the facility on [DATE]. RN 2 stated Resident 118's room assignment was predetermined prior to his arrival to the facility. RN 2 stated Resident 118 was placed in a room close to the lobby door and the idea of a room change crossed her mind due to Resident 118's prior elopement but did not initiate a room change. RN 2 stated the conversation of a room change should have been brought up to initiate a room change away from an entrance/exit door and closer to the nurse's station. g. During a concurrent interview and record review on 1/28/2025 at 11:07 a.m., with the MDSC, Resident 118's IDT Meeting Notes were reviewed. The IDT Meeting Notes did not indicate Resident 118's high risk for wandering and elopement and elopement on 10/13/2024 were addressed. The MDSC stated the facility did not conduct an IDT meeting after Resident 118 was readmitted to the facility on [DATE] following his elopement on 10/13/2024 nor after Resident 118 was assessed as a high risk for wandering and elopement. The MDSC stated conducting an IDT meeting when Resident 118 was readmitted to the facility was important to find out the reason Resident 118 eloped from the facility on 10/13/2024. The MDSC stated during the IDT meeting, the facility could have assisted Resident 118 with a safe discharge if that was desired or addressed other concerns that prompted Resident 118 to elope from the facility. The MDSC stated during the IDT meeting, Resident 118 would have been educated on the important of safety and encouraged not to elope from the facility due to the risk of getting hit by a car or ultimately death. The MDSC stated because the IDT did not address Resident 118's reason for eloping nor his high risk for wandering and elopement, the IDT was unable to create a plan of care to prevent another elopement. The MDSC stated Resident 118 eloped from the facility a second time on 11/24/2024. During an interview on 1/28/2025 at 2:52 p.m., with the DON, the DON stated an IDT meeting was necessary after an elopement to have an in-depth conversation with the resident to reeducate him on safety and the process of safely leaving the facility, to create a plan of care decided by all departments, and to address any concerns and provide the necessary assistance. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	h. During an interview on 1/28/2025 at 12:20 p.m., with the Director of Staff Development (DSD), the DSD stated she did not in-serviced any staff on monitoring, supervision, safety, elopement, and wandering. The DSD stated any communication on monitoring and supervision would be between the licensed nurses to the CNAs regarding their assigned residents. The DSD stated there was no lesson plan that outlined how to monitor and supervise high risk for elopement and wandering residents. During an interview on 1/28/2025 at 12:26 p.m., with RN 2, RN 2 stated she did not receive any in-services on elopement and wandering residents nor how to monitor them. RN 2 stated she would instruct the other nurses and CNAs to conduct more visual monitoring if they had residents at risk for wandering and elopement. During an interview on 1/29/2025 at 9:10 a.m., with LVN 1, LVN 1 stated she was never in serviced or trained on how to monitor residents at risk for wandering and elopement. LVN 1 stated she used her nursing judgement to ensure Resident 118 and other residents at risk did not wander off or elope from the facility. During an interview on 1/29/2025 at 2:49 p.m., with CNA 2, CNA 2 stated she had not received an in-service on monitoring and supervising high risk for elopement residents. CNA 2 stated she knew those residents required close monitoring and to keep an eye them, however, it was impossible to watch them every moment of the shift. During an interview on 1/28/2025 at 2:52 p.m., with the DON, the DON stated in-services on monitoring high risk for wandering and elopement residents was important to bring awareness to the staff and to allow any staff member to ask questions if they did not know how to handle the situation. The DON stated in-services ensured a standard level of education and competency between all staff members. During a review of the facility's P&P titled, Safety and Supervision of Residents, undated, the P&P indicated, The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for that resident. The care team shall target interventions to reduce the potential for accidents. The P&P indicated to reduce accident risks and hazards, the facility shall provide training, as necessary. The P&P indicated, The facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjust interventions accordingly. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. During a review of the facility's P&P titled, Wandering, Unsafe Resident, revised 8/2014, the P&P indicated, The staff will identify residents who are at risk for harm because of unsafe wandering (including elopement) . The resident's care plan will indicate the resident is at risk for elopement or other safety issues. Interventions to try to maintain safety, such as a detailed monitoring plan will be included. Cross Reference F656. 47286 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. During a review of Resident 117's Admission Record, the Admission Record indicated Resident 117 was admitted on [DATE]. Resident 117's diagnoses included a broken right thigh bone and displacement of internal fixation device of the right thigh bone (when a surgical implant, like a plate, screw, or rod used to stabilize a broken bone, has moved out of its original position). During a review of Resident 117's History and Physical (H&P), dated 5/7/2024, the H&P indicated Resident 117 had the capacity to understand and make decisions. During a review of Resident 117's admission Minimum Data Set (MDS, a resident assessment tool), dated 5/16/2024, the MDS indicated Resident 117 did not have cognitive impairments (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 117 was independent with mobility while in bed and was dependent on staff to walk. During a review of Resident 117's discharge MDS, dated [DATE], the MDS indicated Resident 117 was independent in making decisions regarding tasks of daily life, and decisions were consistent and reasonable. The MDS indicated Resident 117 could walk independently. During a review of Resident 117's progress note, dated 11/6/2024, the progress note indicated Resident 117 was non-compliant with facility rules and had displayed aggressive behavior towards facility staff. During a review of Resident 117's progress note, dated 11/9/2024 at 12:33 a.m., the progress note indicated Resident 117 was out of the facility on a pre-approved four-hour leave, and did not return within four hours. The progress note indicated Resident 117 was discharged from the facility, and indicated staff attempts to contact Resident 117 were unsuccessful. During a review of Resident 117's progress note, dated 11/9/24 at 7:15 a.m., the progress note indicated Resident 117 arrived at the facility by bicycle and entered through a back door. The progress note indicated Resident 117 was informed he was discharged from the facility and was trespassing and indicated Resident 117 refused to leave. The progress note indicated nursing Registered Nurse (RN) 1 called law enforcement and Resident 117 was escorted from the facility by law enforcement. During a review of Resident 117's progress note, dated 11/9/24 at 2:26 p.m., the progress note indicated Resident 117 returned to the facility on bicycle, accompanied by a vehicle with two unidentified individuals. The progress note indicated Resident 117 arrived at the facility through a staff-only gated entrance that required a code. The progress note indicated Resident 117 knew the code. The progress note indicated Resident 117 then entered the building through a door used by housekeeping staff and was very aggressive and brandishing a large knife. The progress note indicated Resident 117 was yelling expletives and indicated law enforcement was contacted but never arrived. On 1/31/2024 at 9:29 a.m., an attempt was made to contact Resident 117 by telephone. Resident 117's contact number was disconnected. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/31/2025 at 10:16 a.m., with RN 1, RN 1 stated Resident 117 trespassed onto the facility premises on 11/9/2024 in the morning and stated the Director of Nursing (DON) was notified by phone. RN 1 stated Resident 117 returned to the facility later in the day on 11/9/2024, with a huge knife. RN 1 stated Resident 117 was irate and super aggressive towards staff. RN 1 stated law enforcement was contacted and never arrived at the facility. RN 1 stated that during both trespassing incidents, Resident 117 snuck through the staff-only gate, using the code to gain entry. During an interview on 1/31/2025 at 12:05 p.m., with the DON, the DON stated Resident 117 trespassed onto the facility premises with a large knife and entered through entrances not approved for visitors or residents. The DON stated the gate code to the parking lot was not changed between both trespassing incidents. The DON stated knowing the code created a potential for Resident 117 to trespass onto the facility premises. During a concurrent interview and record review, on 1/31/2025 at 12:57 p.m., with the Administrator (ADM), the facility policy and procedure (P&P) titled Unusual Occurrence Reporting, undated, was reviewed. The ADM stated the P&P indicated occurrences that affect the welfare and safety of facility residents were to be reported to the State agency (SA). The ADM stated Resident 117's trespass onto the facility premises with a large knife was an immediate risk to the welfare and safety of the facility residents and staff, and state it should have been reported to the SA. The ADM stated the facility staff and residents were in fear, and stated Resident 117 created an unsafe environment. During a review of the facility P&P titled Unusual Occurrence Reporting, undated, the P&P indicated occurrences that affect the welfare and safety of facility residents and staff were to be reported via telephone to the SA within 24 hours, and a written report detailing the incident was to be sent to the SA within 48 hours. 3. a. During a review of Resident 319's Admission Record, the Admission Record indicated Resident 319 was admitted on [DATE]. Resident 319's admitting diagnoses included generalized muscle weakness and schizophrenia (mental illness that is characterized by disturbances in thought). During a review of Resident 319's H&P, dated 1/2/2025, the H&P indicate Resident 319 had the capacity to understand and make decisions. During a review of Resident 319's MDS, dated [DATE], the MDs indicated Resident 319 did not have cognitive impairments or impairments to his upper extremities (shoulders, elbows, wrists, hands). During a review of Resident 319's Smoking Assessment, dated 1/24/2025, the assessment indicated Resident 319 could light his own cigarettes and the facility did not need to store his lighter and cigarettes. During an observation on 1/27/2025 at 8:58 a.m., at Resident 319's bedside, a pack of cigarettes and a disposable lighter were observed resting on Resident 319's bedside table, readily visible. Resident 319 was observed lying in bed, with his face covered by a blanket. b. During a review of Resident 55's Admission Record, the Admission Record indicated Resident 55 was admitted on [DATE]. Resident 55's admitting diagnoses included dementia (a progressive state of decline in mental abilities) and generalized muscle weakness. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 55's H&P, dated 1/5/2024, the H&P indicated Resident

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on observation, interview, and record review, the facility failed to ensure that a meal substitute provided to one of five sampled residents (Resident 99) was of equal nutritive value to the meal originally provided. This deficient practice had the potential to result in Resident 99 not receiving the required number of calories, and amount of protein and nutrients needed, and could lead to weight loss, malnutrition, and delayed wound healing. Findings: During a review of Resident 99's Admission Record, the Admission Record indicated Resident 99 was originally admitted on [DATE] and was most recently readmitted on [DATE]. Resident 99's admitting diagnoses included generalized muscle weakness, iron deficiency anemia (a condition where the body does not have enough iron to produce healthy red blood cells), vitamin B-12 deficiency anemia (a condition where the body doesn't have enough healthy red blood cells due to a lack of vitamin B12), and adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 99's Minimum Data Set (MDS, a resident assessment tool), dated 11/26/2024, the MDS indicated Resident 99 did not have cognitive impairments (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 99 was dependent on staff to eat. During a review of Resident 99's diet order, dated 11/7/2024, the diet order indicated Resident 99 was to receive a fortified diet (foods that have had nutrients added to them that are not normally present), and double portions for all meals. During an observation on 1/28/2025 at 9:51 a.m., at Resident 99's bedside, Resident 99 was observed thin. Resident 99 stated he had recently lost a lot of weight, and stated he relied on facility staff to provide his meals and to feed him. During an observation on 1/28/2025 at 1:40 p.m., Resident 99's lunch tray was observed on a collection cart for trays that had been eaten. Resident 99's tray was observed untouched, with all food indicated on the tray ticket (a slip of paper that displays exactly what that resident will be receiving, based on the resident's diet order and food preferences) present on the tray. During a concurrent observation and interview, on 1/28/2025 at 1:43 p.m., at Resident 99's bedside, Certified Nursing Assistant (CAN) 2 was observed providing Resident 99 a bean and cheese burrito on a Styrofoam plate, with a small bowl of green salsa. There were no side dishes or additional food items provided. CNA 2 stated she did not offer or provide Resident 99 with the lunch tray originally provided by the kitchen. CNA 2 stated she (CNA 2) requested a bean and cheese burrito substitute because Resident 99 liked Mexican food. CNA 2 stated Resident 99 did not make this request. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/28/2025 at 3:45 p.m., with the Registered Dietician (RD), the RD stated staff should offer the tray provided by the kitchen and allow the resident to accept or decline it. The RD stated a fortified diet would be ordered for residents who were underweight or needed to gain weight, and stated a fortified diet would assist in providing more calories. The RD stated substitutes should have an equivalent number of calories and/or nutritional value. The RD stated that if the substitute did not have the equivalent number of calories and/or nutritional value, then it was possible the resident would not meet their nutritional needs. During an interview on 1/28/2025 at 4:15 p.m., with the Dietary Supervisor (DS), the DS stated the bean and cheese burrito was served alone and was not served with any additional side dishes. The DS stated the burrito was meant to substitute the main dish, and not the side dishes. During an interview on 1/28/2025 at 4:24 p.m., with the RD, the RD stated that if a substitute was not served with the originally provided side dishes, the substitute alone would not have the same nutritive value as a whole meal. The RD stated Resident 99 was supposed to receive a fortified tray with double portions, which increased the number of calories and/or nutrients he was supposed to receive. During a review of the dietary spreadsheet, dated 1/28/2025, the spreadsheet indicated the breakfast, lunch, and dinner meals served on 1/28/2025. The spreadsheet indicated Resident 99 was supposed to receive two smothered pork chops as his main dish, along with double portions of two side dishes. During a review of the facility document titled Cycle 1 2025 Winter - Regular Analysis, dated 2002 to 2025, the document indicated two smothered pork chops (double portion) had 384 calories and 43.4 grams of protein, and double portions of the side dishes had a combined total of 362 calories and 9.8 grams of protein. In total, Resident 99's original tray had 746 calories and 53.2 grams of protein from the main dish and side dishes. The document indicated the bean and cheese burrito Resident 99 received in place of his original tray had 408 calories and 18.2 grams of protein.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009 Based on observation, interview, and record review, the facility failed to ensure the nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) tubing was dated, not touching the floor, and an oxygen in use sign was posted outside the room for three out of eight sampled residents (Resident 100, 103, and 269) receiving oxygen therapy. These deficient practices had the potential to cause a negative respiratory outcome, increased the risk for Resident 100, 103 and 269 to acquire a respiratory infection and placed resident 100 at risk of injury due to fire hazard. Findings: a. During an observation on 1/27/2025 at 11:13 a.m., in Resident 269's room, Resident 269's nasal cannula tubing was observed undated and touching the floor. During an observation on 1/28/2025 at 9:42 a.m., in Resident 269's room, Resident 269's nasal cannula tubing was observed undated and touching the floor. During a review of Resident 269's Admission Record, the admission record indicated Resident 269 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 269's diagnoses included respiratory failure (serious condition that makes it difficult for a person to breath on their own, lungs can't get enough oxygen into the blood) and quadriplegia (paralysis from the neck down, including the trunk, legs and arms). During a review of Resident 269's History and Physical (H&P) dated 12/15/2024, the H&P indicated Resident 269 did not have the capacity to understand and make decisions. The H&P indicated Resident 269 was able to make decisions for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 269's Minimum Data Set (MDS), (a mandated resident assessment tool), dated 1/23/2025, the MDS indicated Resident 269's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was severely impaired. The MDS indicated Resident 269 was dependent on staff for all ADLs. b. During an observation on 1/27/2025 at 12:32 p.m., in Resident 100's room, Resident 100's nasal cannula tubing was undated. There was no signage indicating oxygen was in use posted outside of Resident 100's room. During an observation on 1/28/2025 at 9:58 a.m , in Resident 100's room, Resident 100's nasal cannula tubing was undated. There was no signage indicating oxygen was in use posted outside of Resident 100's room. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 100's Admission Record, the admission record indicated Resident 100 was admitted to the facility on [DATE]. Resident 100's diagnoses included diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing) and generalized muscle weakness (loss of muscle strength, develops suddenly or gradually). During a review of Resident 100s H&P dated 3/28/2024, the H&P indicated Resident 100 was alert to person, place, and time. During a review of Resident 100's MDS, dated [DATE], the MDS indicated Resident 100's cognitive skills for daily decision making was intact. The MDS indicated Resident 100 was independent for all ADLs. During an interview on 1/28/2025 at 10:14 a.m. with Resident 100, Resident 100 stated she had the same nasal cannula tubing for a long time. Resident 100 stated the tubing was not replaced weekly. Resident 100 stated she asked staff to give her a new nasal cannula but the staff did not. Resident 100 stated she never saw nursing staff date her nasal cannula. c. During an observation on 1/30/2025 at 10:01 a.m., in Resident 103's room, Resident 103's nasal cannula was observed undated and touching the floor. During a review of Resident 103's Admission Record, the admission record indicated Resident 100 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 103's diagnoses included kidney failure (when kidneys are unable to filter waste products from the blood) and cardiomegaly (a condition where the heart becomes enlarged, or larger than normal). During a review of Resident 103's H&P dated 8/13/2024, the H&P indicated Resident 103 had the capacity to understand and make decisions. During a review of Resident 103's MDS, dated [DATE], the MDS indicated Resident 103's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 103 required supervision for oral hygiene and personal hygiene. The MDS indicated Resident 103 required set up and clean up assistance for eating. During a concurrent observation and interview on 1/30/2025 at 10:06 a.m. with Licensed Vocational Nurse (LVN) 7, in Resident 103's room, Resident 103's nasal cannula was observed undated with no opened date. LVN 7 stated nasal cannulas must be dated when it was newly placed on the resident. LVN 7 stated all nasal cannulas must be dated to notify all staff how long the resident has used it. LVN 7 stated all nasal cannulas must be dated for infection control. LVN 7 stated she did not know how often nasal cannulas must be changed. LVN 7 stated an Oxygen in Use sign must be placed outside of the resident room door for oxygen administration safety. LVN 7 stated it was important to display the sign to prevent residents, staff and visitors from smoking in that area. During a review of the facility's Policy and Procedure (P&P) titled Oxygen Administration dated 2010, the P&P indicated an Oxygen in Use sign must be placed outside of resident room entrance door and on a designated place on or over resident's bed.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on observation, interview, and record review, the facility failed to follow its policy and procedure (P&P) titled Proper Use of Side Rails, which indicated consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for side rail use would be obtained from the resident, after presenting potential benefits and risks for four of eight sampled residents (Resident 75, Resident 42, Resident 71, and Resident 6). This deficient practice had the potential to result in inappropriate use of side rails for Residents 75, 42, 71, and 6, and could lead to injury. Findings: a. During a review of Resident 75's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 75 was admitted to the facility on [DATE]. Resident 75's diagnoses included dysphagia (difficulty swallowing), muscle weakness (loss of muscle strength), and hypertension ([HTN]- high blood pressure. During a review of Resident 75's Minimum Data Set ([MDS]-a resident assessment tool), dated 1/8/2025, the MDS indicated Resident 75's cognitive (the ability to think and process information) skills for daily decisions making was intact. The MDS indicated Resident 75 was independent (resident complete the activity by himself) for eating, toilet hygiene, and upper body dressing. The MDS indicated Resident 75 required moderate (helper does less than half the effort) assistance from staff for showering/bathing. During a concurrent observation and interview on 1/27/2025 at 9:23 a.m., with Resident 75, in Resident 75's room, Resident 75 was observed lying in bed. Resident 75's bed had quarter side rails on the left and right side of the bed. Resident 75 stated he used the side rails to assist him moving in and out of the bed. Resident 75 stated the facility did not inform him of the risks and benefits for using the side rails. During a concurrent interview and record review on 1/30/2025 at 12:05 p.m., with the Director of Nursing (DON), Resident 75's electronic medical record (eMAR) was reviewed. The DON stated Resident 75 used side rails for bed mobility. The DON stated Resident 75 did not have an informed consent, and there was no documentation indicating Resident 75 was informed the risks and benefits for side rails use. b. During a review of Resident 42's Face Sheet, the Face Sheet indicated Resident 42 Resident 42 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 42's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), muscle weakness, and dysphagia. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 42's MDS, dated [DATE], the MDS indicated Resident 42's cognitive skills for daily living was moderately impaired. The MDS indicated Resident 42 required moderate assistance from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent observation and interview on 1/27/2025 at 10:17 a.m., with Certified Nursing Assistant (CNA 4), in Resident 42's room, CNA 4 stated Resident 42 was observed lying in bed and had quarter side rails on the left and right side of the bed. CNA 4 stated Resident 42 had bilateral (pertaining to both sides) side rails on the bed to enable the resident's functional mobility. CNA 4 stated she was not aware if an informed consent was required for the use of bed side rails. During a concurrent interview and record review on 1/30/2025 at 12:15 p.m., with the DON, Resident 42's eMAR was reviewed. The DON stated there was no informed consent for Resident 42's bed side rails use. c. During a review of Resident 71's Face Sheet, the Face Sheet indicated Resident 71 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 71's diagnoses included hemiplegia and hemiparesis (total paralysis of the arm, leg, and trunk on the same side of the body), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and hypertension ([HTN]- high blood pressure. During a review of Resident 71's MDS, dated [DATE], the MDS indicated Resident 71's cognitive skills for daily decision making was intact. The MDS indicated Resident 71 required moderate assistance from staff for ADLs. During a concurrent observation and interview on 1/27/2025 at 11:55 a.m., with Resident 71, in Resident 71's room, Resident 71 was observed seating on the bed and had quarter side rails on both sides of the bed. Resident 71 stated the bed had side rails upon his admission to the facility. Resident 71 stated he used the side rails for bed mobility. Resident 71 stated staff had not provided him with an informed consent for side rails use. During a concurrent interview and record review on 1/30/2025 at 12:30 p.m., with the DON, Resident 71's eMAR was reviewed. The DON stated he was not able to locate an informed consent for Resident 71's side rails use, and there was no documentation for side rails safety use. d. During a review of Resident 6's Face Sheet, the Face Sheet indicated Resident 6 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses included hemiplegia and hemiparesis, dysphagia (difficulty swallowing), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6 cognitive skills for daily decision making was intact. The MDS indicated Resident 6 required supervision or touching (helper provides verbal cues and/or touching assistance as resident completes activity) assistance from staff for ADLs. During an observation on 1/27/2025 at 12:33 p.m., in Resident 6's room, Resident 6's bed was observed placed against the wall, with the right side of the bed touching the wall. Resident 6's bed had quarter bilateral side rails placed upper position. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/30/2025 at 12:45 p.m., with the DON, the DON stated it was the resident rights to be informed about the treatment and services provided at the facility. The DON stated informed consent should have been obtained from the residents for bed side rails use, and residents should have been instructed on the risks and benefits for side rails use. The DON stated it was important for residents to be informed about the risks and benefits for side rails use for resident safety and prevent injury. During a review of the facility's P&P titled Bed Safety, revised 12/2007, the P&P indicated facility shall strive to provide a safe sleeping environment for the resident. The P&P indicated facility's staff shall obtain informed consent from the resident for the use of side rails. During a review of the facility's P&P tilted Proper Use of Side Rails, revised 12/2016, the P&P indicated facility would ensure the safe use of the side rails as resident mobility aid. The P&P indicated informed consent for side rails use would be obtained from the resident after presenting potential benefits and risks.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on interview and record review, the facility failed to ensure residents were seen by a physician at least once every 30 days, for the first 90 days after admission, for one of three sampled residents (Resident 60). This deficient practice resulted in Resident 60 receiving an initial comprehensive visit on 10/20/2024, and subsequent monthly visits on 11/30/2024 and 12/29/2024, from a non-physician provider (NPP), Nurse Practitioner (NP, a registered nurse who has advanced training to diagnose and treat patients) 1, whose scope of practice was different and more limited than that of a physician. Findings: During a review of Resident 60's Admission Record, the Admission Record indicated Resident 60 was admitted on [DATE]. Resident 60's admitting diagnoses included multiple sclerosis (a chronic disease that affects the brain and spinal cord), chronic kidney disease (a long-term condition where the kidneys gradually lose their ability to filter waste products from the blood), schizophrenia (a mental illness that is characterized by disturbances in thought), and atherosclerotic heart disease (a condition where plaque builds up in the blood vessels of the heart, narrowing them and reducing blood flow). During a review of Resident 60's Minimum Data Set (MDS, a resident assessment tool), dated 10/30/2024, the MDS indicated Resident 60 had severe cognitive impairments (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 60 required partial to moderate assistance from staff with mobility while in and out of bed. The MDs indicated Resident 60 required substantial to maximal assistance from staff for toileting hygiene, bathing herself, dressing her lower body, and putting on/taking off footwear. During a review of Resident 60's History and Physical (H&P), dated 10/20/2024, the H&P indicated Resident 60 had fluctuating capacity to understand and make decisions. The H&P was signed by Nurse Practitioner (NP) 1. During a review of Resident 60's progress note, dated 11/30/2024, the note indicated Resident 60 was seen by NP 1 for a monthly visit. During a review of Resident 60's progress note, dated 12/29/2024, the note indicated Resident 60 was seen by NP 1 for a monthly visit. During a concurrent interview and record review, on 1/29/2025 at 3:24 p.m., with the Medical Records Director (MRD), Resident 60's H&P, dated 10/20/2024, and progress notes dated 11/30/2024 and 12/29/2024, were reviewed. The MRD stated the H&P was where physicians documented their initial comprehensive visit and assessment of newly admitted residents, and stated Resident 60's H&P, dated 10/20/2024, indicated Resident 60 was seen by NP 1. The MRD stated the H&P dated 10/20/2024, and progress notes dated 11/30/2024 and 12/29/2024, indicated Resident 60's physician did not complete an in-person visit since her admission on 10/18/2024. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/30/2025 at 8:52 a.m., NP 1, NP 1 stated she provided care to facility residents under the supervision of a physician. NP 1 stated she occasionally conducted the initial visits for newly admitted residents. NP 1 stated she could not recall if Resident 60's physician saw Resident 60 since her admission on 10/18/2024. During an interview on 1/30/2025 at 1:14 p.m., with the Director of Nursing (DON), the DON stated that according to federal regulations, the first visit for a newly admitted resident was to be conducted by a physician, and not an NPP. The DON stated it was important residents were seen by a physician to ensure the plan of care was adequate and appropriate for the residents' needs. The DON stated the physician's scope of practice (the range of activities that a healthcare professional is allowed to perform) was broader than that of a NPP. During a review of the facility's policy and procedure (P&P) titled Physician Services, revised 4/2013, the P&P indicated the resident's attending physician was to participate in the resident's assessment and care planning and oversee a relevant plan of care for the resident. The P&P further indicated physician visits, and the frequency of visits, were to be provided in accordance with current federal regulations.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on interview and record review, the facility failed to conduct competency skills evaluation for five of five sampled employees Certified Nursing Assistant (CNA 1), CNA 4, CNA 2, Registered Nurse (RN 2), and Licensed Vocational Nurse (LVN 1), by failing to: 1. Ensure competency skills evaluation was conducted upon hire date and annually for CNA 1 and CNA 4. 2. Ensure competency skills evaluation was conducted annually for CNA 2. 3. Ensure competency skills evaluation was conducted upon hire date for RN 2 and LVN 1. This deficient practice had the potential to result in licensed employees being unaware of any areas in their competency skills required and/or improvement to provide care and services for the residents in the facility. Findings: 1. During a concurrent interview and record review on 1/29/2025 at 3:06 p.m., with the Director of Staff Development (DSD), three employees' personal records were reviewed. The DSD stated competency skills evaluation was one the required pre-requisites for employment and was her responsibilities as a DSD to conduct CNAs competency skills evaluation upon hire and annually. The DSD stated: a) CNA 1 was hired on 9/18/2019 and there was no competency skills evaluation on file upon hire and/or annually (2019-[AGE] year). b) CNA 4 was hired on 6/21/2022 and there was no competency skills evaluation on file upon hire and/or annually (2022-[AGE] year). c) CNA 2 was hired on 4/14/2017 and the last competency skills evaluation was conducted on 9/12/2019, there was no competency skills evaluation on file annually after that (2020-[AGE] year). The DSD stated the purpose of the competency skills evaluation was to review how the employee was performing and to discuss their strengths and to improve any weaknesses in any of the skills required to provide quality residents' care. The DSD stated the competency skills evaluation was a tool for her to determine the education and skills that needed to be provided to encourage better skills performance and for better resident care. The DSD stated it was important to conduct competency skills evaluation upon hire and annually to ensure the employees were competent with the skills required to care for the residents in the facility. 2. During a concurrent interview and record review on 1/30/2025 at 10:10 a.m., with the Director of Nursing (DON) two employees' personal records were reviewed. The DON stated: (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	d) RN 2 was hired on 9/30/2024 and there was no competency skills evaluation on the file upon hire date. e) LVN 1 was hired on 6/24/2024 and there was no competency skills evaluation on file upon hire date. The DON stated he was responsible for conducting the competency skills evaluation for the LVNs, and RNs to determine if the licensed staff had the necessary skills to provide care and treatments for residents in the facility. The DON stated competency skills evaluation should be conducted upon hire date and then on an annual basis. The DON stated it was important the competency skills evaluation was conducted upon hire and annually to determine the skills area the nurse required training and/or improvement. The DON stated without the competency skills evaluation would not be able to collaborate with the nurses on how nurses could improve. During a review of the facility's policy and procedure (P&P) tilted Job Description- Director of Staff Development and Education [DSD]), undated, the P&P indicated the DSD was responsible for planning, implementing, and evaluating the staff. The P&P indicated the DSD would conduct competencies evaluation and maintenance. The P&P indicated the DSD would maintain appropriate documentation of staff competency skills. During a review of the facility's P&P titled Job Description-Director of Nursing (DON), undated, the P&P indicated the DON would coordinate clinical team and would ensure the clinical team had the clinical expertise and certification required for the resident population. The P&P indicated the DON would hire and orient professional nursing staff and would review and evaluate the performance of nursing staff.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on observation, interview, and record review, the facility failed to accurately account for one dose of lorazepam (a controlled medication used to treat mental illness) 0.5 milligrams (mg - a unit of measure for mass) affecting Resident 47 in one of two inspected medication carts (East Cart), and ensure licensed nurses administered intravenous (IV, a method of administering fluids or drugs directly into a vein using a needle or tube) medication as ordered and the IV access site was monitored per the doctor's orders for one of eight sampled residents (Resident 115). These deficient practices increased the risk of diversion (any use other than that intended by the prescriber) of controlled mediations and the risk that Resident 47 could have received too much or too little medication due to lack of documentation possibly resulting in serious health complications requiring hospitalization , and caused Resident 115 to have an interruption with antibiotic therapy, and exposed Resident 115 to a potential risk of having an IV infection and/or having a non-working IV due to lack of IV site monitoring. Findings: 1. During an observation and concurrent interview of East Cart on 1/28/2025 at 11:55 a.m., with Licensed Vocational Nurse (LVN 4) the following discrepancies were found between the Controlled Medication Count Sheet (a log signed by the nurse with the date and time each time a controlled substance is given to a resident) and the medication card (a bubble pack from the dispensing pharmacy labeled with the resident's information that contains the individual doses of the medication): Resident 47's Controlled Medication Count Sheet for lorazepam 0.5 mg indicated there were 12 doses left, however, the medication card contained 11 doses. During a concurrent interview, LVN 4 stated she administered the missing dose of lorazepam that morning (1/28/2025) around 9:30 AM but failed to sign the Controlled Drug Count Sheet at that time because she was distracted by other tasks. LVN 4 stated the Controlled Drug Record was required to be signed immediately after the time of administration of the medication to ensure the resident did not receive more often than prescribed. LVN 4 stated if Resident 47 received lorazepam more often than prescribed, it could cause medical complications possibly leading to hospitalization . During a review of the facility's undated policy and procedure (P&P) titled Controlled Substances, the P&P indicated .an individual resident controlled substance record must be made for each resident who will be receiving a controlled substance . This record must contain: . number on hand . time of administration . signature of nurse administering medications . 45009 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a review of Resident 115's Admission Record, the admission record indicated Resident 115 was admitted to the facility on [DATE] with diagnoses including abscess (swollen area within body tissue, containing an accumulation of pus) of prostate (a gland in the male reproductive system) and diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 115's History and Physical (H&P) dated 1/10/2025, the H&P indicated Resident 115 had the capacity to understand and make decisions. During a review of Resident 115's Minimum Data Set (MDS), a mandated resident assessment tool), dated 1/19/2024, the MDS indicated Resident 115's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was intact. The MDS indicated Resident 115 was independent t for activities of daily living. During a review of Resident 115's Order Summary Report, dated 1/7/2025, the order summary report indicated Resident 115 had an order for Meropenem 1 gram ([gm] metric unit of measurement, used for medication dosage and/or amount) for prostate abscess, intravenously every eight hours until 2/4/2025. The order summary report indicated Resident 115 was scheduled to receive the medication at 6:00 a.m., 2:00 p. m. and 10:00 p.m. The order summary report indicated the order was discontinued on 1/25/2025. During a review of Resident 115's Order Summary Report, dated 1/25/2025, the order summary report indicated Resident 115 had an order to administer Meropenem 1 gm for prostate abscess, intravenously every eight hours until 2/4/2025. The order indicated Resident 115 was scheduled to receive the medication at 2:00 a.m., 10:00 a.m. and 6:00 p.m. The order summary report indicated the order was discontinued on 1/27/2025. During a review of Resident 115's Order Summary Report, dated 1/27/2025, the order summary report indicated Resident 115 had an order to administer Meropenem 1 gm for prostate abscess, intravenously every eight hours until 2/4/2025. The order indicated Resident 115 was scheduled to receive the medication at 6:00 a.m., 2:00 p.m. and 10:00 p.m. During a review of Resident 115's Order Summary Report, dated 1/7/2025, the order summary report indicated Resident 115 had an order to check the resident's IV site for redness, pain at the insertion site, swelling, infiltration (intravenous fluids accidentally leak out of the vein and into the surrounding tissue) and phlebitis (inflammation of a vein near the surface of the skin), adverse reaction to infusion (method of putting fluids, or drugs into the bloodstream), ensure the IV device is intact and provide a 10 milliliters ([ml] metric unit of measurement, used for medication dosage and/or amount) saline flush (a mixture of salt and water that is used to push any residual medication or fluid through the IV line and into your vein) every eight hours before and after medication administration. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 115's Medication Administration Record (MAR), dated 1/7/2025, the MAR indicated Resident 115 was to receive Meropenem for prostate abscess, intravenously every eight hours until 2/4/2025. The MAR indicated Resident 115 was scheduled to receive the medication at 6:00 a.m., 2:00 p.m. and 10:00 p.m. The MAR indicated Resident 115 did not receive meropenem on 1/8/2025 at 2:00 p.m., 1/9/2025 at 2:00 p.m. and 10:00 p.m., 1/10/2025 at 2:00 p.m., 1/11/2025 at 6:00 a.m., 1/12/2025 at 6:00 a.m. , 1/13/2025 at 2:00 p.m., 1/15/2025 at 10:00 p.m., 1/17/2025 at 6:00 a.m., 1/20/2025 10:00 p.m., 1/21/2025 at 6:00 a.m., 1/22/2024 at 10:00 p.m., and 1/25/2025 at 6:00 a.m. During a review of Resident 115's MAR, dated 1/25/2025, the MAR indicated Resident 115 was to receive meropenem for prostate abscess, intravenously every eight hours until 2/4/2025. The MAR indicated Resident 115 was scheduled to receive the medication at 2:00 a.m., 10:00 a.m., and 6:00 p.m. The MAR indicated Resident 115 did not receive meropenem on 1/27/2025 at 2:00 a.m. During a review of Resident 115's MAR, dated 1/27/2025, the MAR indicated Resident 115 was to receive meropenem for prostate abscess, intravenously every eight hours until 2/4/2025. The MAR indicated Resident 115 was scheduled to receive the medication at 6:00 a.m., 2:00 p.m. and 10:00 p.m. The MAR indicated Resident 115 did not receive meropenem on 1/29/2025 at 10:00 p.m., and on 1/30/2024 at 10:00 p. m. During a review of Resident 115 electronic medical record, unable to locate nursing progress notes that indicated the reason why Resident 115 did not receive meropenem on 1/27/2025. During a review of Resident 115's MAR, dated 1/7/2025, the MAR indicated to monitor Resident 115's IV access site for redness, pain at the insertion site, swelling, infiltration, adverse reaction to the infusion, and securement device was intact, IV site had to be flushed with 10ml of saline before and after medication administration and IV tubing had to be changed every 24 hours. During a review of Resident 115's care plan titled Antibiotic Therapy for prostate abscess, dated 1/8/2025, the care plan indicated Resident 115's goal was to be free from infection. The care plan interventions indicated to administer 1 gram of meropenem intravenously every eight hours, change the IV tubing every 24 hours, check the IV site for redness, pain at insertion site, swelling, infiltration or phlebitis, adverse reaction to infusion, IV device intact and 10 ml saline flush every eight hours before and after medication administration. During an interview on 1/27/2025 at 10:29 a.m. with Resident 115, Resident 115 stated he was concerned with the care in the facility because he did not receive his antibiotic medication as he should. Resident 115 stated he did not receive his 2:00 a.m. and 10:00 a.m. doses of meropenem. Resident 115 stated he was told that he did not get his medication because staff could not find the keys for the medication cart. Resident 115 stated this was not the first time the nurses did not give him his medication. Resident 115 stated he was concerned that the antibiotic medication was not going to help him because he did not receive it consistently. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/29/2025 at 8:14 a.m. with RN 1, RN 1 stated Resident 115 was receiving antibiotics but did not know why. RN 1 stated Resident 115 did not receive meropenem on 1/27/2025 at 2:00 a.m. because the 11 p.m. to 7 a.m. (night) shift RN could not find the keys to the medication cart. RN 1 stated Resident 115 had previously missed several other meropenem doses and did not know why. RN 1 stated Resident 115 medication administration times changed three times due to missed doses. RN 1 stated when a nurse did not administer a medication, the nurse must inform the resident and doctor why it was not administered, and document the reason why it was not administered on the MAR and in the nursing progress notes. RN 1 stated she called Resident 115's doctor to change Resident 115's medication administration times because he missed his 2:00 a.m. dose on 1/27/2025. RN 1 stated she did not document the notification to Resident 115's doctor of the missed medication administration. RN 1 stated Resident 115 must receive full antibiotic treatment for it to be effective and could potentially be harmful not to take the full treatment. RN 1 stated an incomplete antibiotic treatment could potentially cause Resident 115 to develop a resistance to the antibiotic and would not resolve Resident 115's prostate abscess. During a concurrent interview and record review on 1/29/2025 at 8:38 a.m. with RN 1, Resident 115's MAR, dated 1/1/2025 - 1/29/2025 was reviewed. The MAR indicated on multiple days, there were no licensed staff initials in the box for meropenem, to demonstrate the medication was administered. The MAR indicated on multiple days, there were no licensed staff initials in the box indicating the monitoring of Resident 115's IV site, flushing of the IV site and changing of the IV tubing. RN 1 stated blank entries on the MAR meant meropenem was not administered and the IV site monitoring was not performed. RN 1 stated all IV monitoring must be performed to keep the IV free from infection and to be alerted if the IV was not working. During a concurrent interview and record review on 1/29/2025 at 8:50 a.m. with RN 1, Resident 115's Nursing progress notes dated 1/1/2025 - 1/29/2025 were reviewed. RN 1 stated there were no progress notes indicating why Resident 115 did not receive meropenem. RN 1 stated there were no progress notes indicating Resident 115's doctor was notified of the missed doses of meropenem. RN 1 stated she did not document when she informed Resident 115's doctor about the missing meropenem doses and she did not document the doctors' response. During a concurrent interview and record review on 1/30/2025 at 3:11 p.m. with the Infection Preventionist Nurse (IPN), Resident 115's MAR, dated 1/1/2025 - 1/30/2025 was reviewed. The MAR indicated on multiple days, there were no licensed staff initials in the box for meropenem, to demonstrate the medication was administered. The IPN stated Resident 115 had not received meropenem medication routinely and it would not have a therapeutic effect due to the multiple missed doses. The IPN stated it was important for Resident 115 to receive meropenem because he had a history of urinary tract infections (UTI- an infection in the bladder/urinary tract) and sepsis (a life-threatening blood infection). During an interview on 1/31/2025 10:10 a.m. with RN 2, RN 2 stated she had not been informed that Resident 115 had not received his meropenem medication. RN 2 stated during report, the night shift RN did not inform her Resident 115's meropenem was not administered. RN 2 stated Resident 115's missed meropenem dose should have been communicated to her. RN 2 stated not taking medication per the doctor's order decreased the effectiveness of the medication, increased the risk of infection, and increased the risk of sepsis (a life-threatening blood infection). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled Administering Medication, dated 2012, the P&P indicated medications would be administered in a safe and timely matter and as prescribed. The P&P indicated medications must be administered in accordance with the orders, including the required time.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on interview and record review, the facility failed to ensure three of 16 sampled residents (Residents 4, 24, and 71), who were receiving Apixaban, Xarelto, and Eliquis (anticoagulants [medication, used to prevent blood clots from forming in the blood vessels and the heart]) were monitored for side effects and signs and symptoms of bleeding. These deficient practices had the potential to result in Residents 4, 24 and 71 suffering from an undetected hemorrhage (release of blood from a broken blood vessel, either inside or outside of the body), which could result in death. Findings: a. During a review of Resident 4's Admission Record (Face Sheet), the Face Sheet indicated Resident 4 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 4's diagnoses included hemiplegia and hemiparesis (total paralysis of the arm, leg, and trunk on the same side of the body) following a cerebrovascular disease (condition that can disrupt the blood flow to the brain, leading to damage or death of brain cells) affecting the right side, epilepsy (a chronic neurological condition characterized by recurrent, unprovoked seizures), and multiple subsegmental thrombotic pulmonary emboli (blood clots that occur in two or more arteries in the lungs). During a review of Resident 4's Minimum Data Set ([MDS], a resident assessment tool), dated 11/6/2024, the MDS indicated Resident 4's cognition (process of thinking) was intact. The MDS indicated Resident 4 required moderate assistance (helper does less than half the effort) with bathing and lower body dressing and required supervision with upper body dressing and personal hygiene. The MDS indicated Resident 4 was taking an anticoagulant. During a review of Resident 4's Order Recap Report, dated 6/1/2024 through 1/29/2025, the Order Recap Report indicated to administer Apixaban 5 milligrams (mg, unit of measurement), by mouth, two times a day related to multiple subsegmental pulmonary emboli. The order started on 1/17/2025. During a concurrent interview and record review on 1/30/2025 at 9:31 a.m., with Registered Nurse (RN) 1, Resident 4's Care Plan, dated 8/7/2021, was reviewed. The Care Plan Indicated Resident 4 was receiving anticoagulant therapy. The staff interventions indicated to monitor signs and symptoms of bleeding relating to anticoagulant therapy and document every shift. RN 1 stated Resident 4 was receiving Apixaban, which increased Resident 4's risk of bleeding. RN 1 stated Resident 4 should be monitored for any kind of bleeding because any kind of bleeding could be an indication of a more serious medical condition. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/30/2025 at 9:37 a.m., with RN 1, Resident 4's Order Recap Report, dated 6/1/2024 through 1/29/2025 was reviewed. The Order Recap Report indicated to administer Apixaban 5mg, two times a day, for multiple subsegmental pulmonary emboli from 6/5/2024 through 1/16/2025. The Order Recap Report indicated to monitor signs and symptoms of bleeding relating to anticoagulant therapy and to notify Resident's 4's physician if any signs and symptoms of bleeding were present such as passing blood in the urine, passing blood during a bowel movement, severe bruising, prolonged nosebleeds that last longer than ten minutes, bleeding gums, vomiting blood, sudden severe back pain, and/or difficulty breathing or chest pain. RN 1 stated Resident 4 did not have a current order to monitor for any signs or symptoms of bleeding. RN 1 stated Resident 4 went to the hospital and was readmitted to the facility, which required Resident 4's physician's orders to be reordered. RN 1 stated Resident 4's monitoring order was not reordered; therefore, the licensed nurses were not prompted to monitor Resident 4 for any signs and symptoms of bleeding that would require notification to Resident 4's physician. RN 1 stated Resident 4 received Apixaban when she was readmitted to the facility on [DATE] and was not properly monitored for bleeding since, which put Resident 4 at risk of undetected bleeding. b. During a review of Resident 24's Admission Record (Face Sheet), the Face Sheet indicated Resident 24 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 24's diagnoses included heart failure (a condition where the heart is unable to pump enough blood to meet the body's needs), dementia (a progressive state of decline in mental abilities), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 24's MDS, dated [DATE], the MDS indicated Resident 24's cognition was severely impaired. The MDS indicated Resident 24 required maximal assistance (helper does more than half the effort) with toileting, bathing, and dressing. The MDS indicated Resident 24 was receiving an anticoagulant. During a review of Resident 24's Order Recap Report, dated 6/1/2024 through 1/29/2025, the Order Recap Report indicated to give Xarelto 20 mg, by mouth, one time a day for atrial fibrillation (heart rhythm disorder where the heart beats irregularly and rapidly). The order started on 12/22/2024. During a concurrent interview and record review on 1/30/2025 at 9:42 a.m., with RN 1, Resident 24's Care Plan, dated 12/27/2023, was reviewed. The Care Plan Indicated Resident 24 was receiving anticoagulant therapy. The staff interventions indicated to monitor Resident 24 for signs and symptoms of bleeding related to anticoagulant therapy and document every shift. RN 1 stated Resident 24 was receiving Xarelto in the facility, which increased Resident 24's risk of bleeding. RN 1 stated Resident 24 should be monitored for any kind of bleeding and inform Resident 24's physician of any abnormalities. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/30/2025 at 9:42 a.m., with RN 1, Resident 24's Order Recap Report, dated 6/1/2024 through 1/29/2025 was reviewed. The Order Recap Report indicated to administer Xarelto 10 mg, one time a day for deep vein thrombosis ([DVT], a condition where a blood clot forms in a deep vein in the body) prophylaxis (prevention) from 6/8/2024 through 12/22/2024. The Order Recap Report indicated to monitor for signs and symptoms of bleeding related to anticoagulant therapy and to notify Resident's 24's physician if any signs and symptoms of bleeding were present such as passing blood in the urine, passing blood during a bowel movement, severe bruising, prolonged nosebleeds that last longer than ten minutes, bleeding gums, vomiting blood, sudden severe back pain, and/or difficulty breathing or chest pain. This order was active from 6/8/2024 through 12/22/2024. RN 1 stated Resident 24 did not have a current order to monitor for any signs or symptoms of bleeding. RN 1 stated Resident 24 went to the hospital and was readmitted to the facility, which required Resident 24's physician's orders to be reordered. RN 1 stated Resident 24's monitoring order was not reordered; therefore, the licensed nurses were not prompted to monitor Resident 24 for any signs and symptoms of bleeding. RN 1 stated Resident 24 received Xarelto when he was readmitted to the facility on [DATE] and was not properly monitored for bleeding for over a month. RN 1 stated without the proper bleeding monitoring, Resident 24 was at risk of suffering an undetected internal bleeding, which could result in death if not addressed immediately. c. During a review of Resident 71's Admission Record (Face Sheet), the Face Sheet indicated Resident 71 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 71's diagnoses included hemiplegia and hemiparesis, diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), heart failure (a condition when your heart doesn't pump enough blood for your body's need), and hypertension ([HTN]- high blood pressure. During a review of Resident 71's MDS, dated [DATE], the MDS indicated Resident 71's cognitive skills for daily decision making was intact. The MDS indicated Resident 71 required moderate assistance from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent interview and record review on 1/30/2025 at 2:20 p.m., with Registered Nurse (RN 1), Resident 71's Order Summary Report, active order dated 11/22/2024, was reviewed. RN 1 stated the Order Summary Report indicated Resident 71 was to receive Eliquis 5 mg, 1 tablet by mouth two times a day. RN 1 stated the Order Summary Report indicated staff would monitor for signs and symptoms of bleeding related to anticoagulant therapy and document every shift. During a concurrent interview and record review on 1/30/2025 at 2;30 p.m., with RN 1, Resident 71's care plan with a focus of Anticoagulant Eliquis, dated 4/4/2023, was reviewed. RN 1 stated the care plan interventions indicated staff would monitor Resident 71 for signs and symptoms of bleeding related to anticoagulant therapy such as passing blood in urine, severe bruising, prolonged nosebleeds, bleeding gums, vomiting blood and document every shift. RN 1 stated the monitoring of Resident 71's bleeding would be documented in Resident 71's Medication Administration Record (MAR). During a concurrent interview and record review on 1/30/2025 at 2:20 p.m., with RN 1, Resident 71's MAR for the month of January 2025 was reviewed. RN 1 stated she was not able to find documented evidence Resident 71's signs and symptoms of bleeding was monitored on the MAR. RN 1 stated if it was not documented it was not done. RN 1 stated failure to monitor for bleeding for a resident receiving anticoagulant therapy could cause health complications and possibly lead to hospitalization . (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Anticoagulation, revised 9/2012, the P&P indicated, The staff and physician will monitor for possible complications in individuals who are being anticoagulated and will manage related problems. 48343

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on interview and record review, the facility failed to provide monitoring for one of five sampled residents (Resident 9) who was receiving Zyprexa (an antipsychotic medication, a medication that affects the mind, emotions, and behavior), temazepam (a hypnotic medication, a medication used to treat insomnia [difficulty falling asleep, staying asleep, or waking up too early, despite having adequate opportunity for sleep]), haloperidol (an antipsychotic medication), and divalproex sodium (an anticonvulsant medication, a medication used to prevent or treat seizures and can be used to treat behavioral disorders) by failing to: 1. Monitor Resident 9 for side effects for his antipsychotic, anticonvulsant, and hypnotic medications. 2. Monitor Resident 9 for tardive dyskinesia (a neurological condition characterized by involuntary, repetitive, and uncontrollable movements of the body). 3. Monitor Resident 9 for orthostatic hypotension (a drop in blood pressure that occurs when a person stands up from a sitting or lying position). These deficient practices had the potential to result in undetected side effects, worsening tardive dyskinesia, and orthostatic hypotension that could negatively affect Resident 9's safety and well-being. Findings: During a review of Resident 9's Admission Record (Face Sheet), the Face Sheet indicated Resident 9 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included schizophrenia (a mental illness that is characterized by a disturbances in thought), anxiety disorder (a mental health condition characterized by excessive and persistent worry, fear, and unease that can interfere with daily life), and encephalopathy (brain damage that affects how the brain functions). During a review of Resident 9's Minimum Data Set ([MDS], a resident assessment tool), dated 11/19/2024, the MDS indicated Resident 9's cognition was moderate impaired. The MDS indicated Resident 9 required maximal assistance (helper does more than half the effort) with toileting, bathing, lower body dressing, and personal hygiene. The MDS indicated Resident 9 took antipsychotic (medications that affect brain activities associated with mental processes and behavior) and anticonvulsant medication. During a review of Resident 9's History and Physical (H&P), dated 9/25/2024, the H&P indicated Resident 9 had the capacity to understand and make decisions. During a review of Resident 9's Order Recap Report, dated 6/1/2024 through 1/29/2025, the Order Recap Report indicated the following orders: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Give divalproex sodium, 250 milligrams (mg, unit of measurement), by mouth, three times a day for mood disorder as manifested by angry outbursts. 2. Give haloperidol, 5 mg, by mouth, every 12 hours for striking out at staff and preventing necessary care related to schizophrenia. 3. Give temazepam 15mg, by mouth, at bedtime for Resident 9's inability to sleep. 4. Give Zyprexa, 5mg, at bedtime for striking out at staff and preventing care related to schizophrenia. During a concurrent interview and record review on 1/30/2025 at 9:43 a.m., with Registered Nurse (RN) 1, Resident 9's Care Plan, dated 2/26/2021, was reviewed. The Care Plan indicated Resident 9 had a diagnosis of schizophrenia as manifested by striking out, preventing necessary care, episodes of yelling, throwing objects. The Care Plan indicated Resident 9 had some facial movement and had a mood disorder as manifested by angry outbursts. The staff interventions indicated to administer haloperidol 5 mg, divalproex sodium 250 mg, and Zyprexa 2.5 mg, monitor and document anti-psychotic for tardive dyskinesia, every shift, monitor and document any side effects of anti-psychotic medication, monitor blood pressure while lying down and sitting for orthostatic hypotension, and monitor and document any side effects of anticonvulsants. RN 1 stated Resident 9 had a care plan that addressed his use of antipsychotic and anticonvulsant medications that directed the licensed nurse to monitor Resident 9 for orthostatic hypotension, tardive dyskinesia, and side effects of antipsychotic and anticonvulsant medications. During a concurrent interview and record review, on 1/30/2025 at 9:47 a.m., with RN 1, Resident 9's Order Recap Report, dated 6/1/2024 through 1/29/2025, was reviewed. The Order Recap Report indicated to monitor Resident 9 for tardive dyskinesia, every shift, from 5/9/2024 through 12/19/2024, monitor Resident 9's blood pressure while lying down and sitting for orthostatic hypotension, every day shift, from 5/26/2024 through 12/19/2024, monitor Resident 9 for side effects of anti-psychotic medication, every shift, from 5/9/2024 through 12/19/2024, monitor Resident 9 for side effects of anticonvulsant medication, every shift, from 10/4/2024 through 12/19/2024, and monitor Resident 9 for side effects of hypnotic medications, every shift, from 10/4/2024 through 12/19/2024. RN 1 stated Resident 9 did not have any current orders for monitoring side effects of antipsychotic, anticonvulsant, and hypnotic medications; orthostatic hypotension, nor tardive dyskinesia. RN 1 stated Resident 9 went to the hospital and was readmitted to the facility, which required Resident 9's physician's orders to be reordered. RN 1 stated Resident 9's monitoring orders were not reordered; therefore, the licensed nurses were not prompted to monitor Resident 9 for medication side effects, orthostatic hypotension, and tardive dyskinesia. RN 1 stated it was important to monitor for medication side effects, orthostatic hypotension, and tardive dyskinesia to notify Resident 9's physician of any change of condition and to receive new orders. RN 1 stated without the necessary monitoring, Resident 9 was at risk of undetected worsening of tardive dyskinesia, side effects, and hypotension, which would negatively affect Resident 9's safety and well-being. During a review of the facility's policy and procedure (P&P) titled, Antipsychotic Medication Use, undated, the P&P indicated the nursing staff shall monitor and report any side effects and adverse consequences of antipsychotic medications to the Attending Physician

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on observation, interview, and record review, the facility failed to ensure two unopened insulin (a medication used to treat high blood sugar) pens were stored in the refrigerator according to the manufacturer's requirements affecting residents 112 and 114 in one of two inspected medication carts (East Cart). The deficient practices of failing to store medications per the manufacturers' requirements increased the risk that Residents 112 and 114 could have received medication that had become ineffective or toxic due to improper storage possibly leading to health complications resulting in hospitalization or death. Findings: During a concurrent observation and interview on [DATE] at 11:55 a.m. of East Cart with Licensed Vocational Nurse (LVN 4), the following medications were found either expired, stored in a manner contrary to their respective manufacturer's requirements, or not labeled with an open date as required by their respective manufacturer's specifications: 1. One unopened insulin glargine (a medication used to treat high blood sugar) pen for Resident 112 was found stored at room temperature. 2. One unopened insulin glargine pen for Resident 114 was found stored at room temperature. According to the manufacturer's product labeling, unopened insulin glargine pens should be stored in the refrigerator. LVN 4 stated the two glargine insulin pens for Residents 112 and 114 have been stored improperly. LVN 4 stated unopened insulin should always be stored in the refrigerator and only brought to the cart once opened and in use for the residents. LVN 4 stated it was likely that the nurses on the overnight shift who received this delivery from the pharmacy unintentionally stored the insulin in the cart instead of the refrigerator. LVN 4 stated if insulin was not stored properly, it may not work to control blood sugar. LVN 4 stated this increased the risk that Resident 112 and 114 could have had medical complications resulting from poor blood sugar control possibly leading to hospitalization . During a review of the facility's undated policy and procedure (P&P) titled Storage of Medications, the P&P indicated The facility shall store all drugs and biologicals in a safe, secure, and orderly manner . Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 38740 Based on observation, interview, and record review, the facility failed to ensure the standardized recipes for the lunch menu was followed on 1/27/2025 and 1/28/2025 when: 1. Food items listed on the menu were not available and were replaced with other items without the registered dietician (RD) approval. 2. Residents receiving a mechanical soft diet (a modified diet that consists of soft, easily chewed foods that can be safely swallowed by individuals with difficulty chewing or swallowing) received shredded instead of ground pork pot roast per the menu. Residents receiving a pureed diet (foods that have been blended or mashed into a smooth, uniform consistency) received bread slurry (bread soaked in milk and melted margarine-the mixture was thin and lumpy and not cohesive) instead of pureed bread that was smooth with no lumps. These deficient practices had the potential to result in meal dissatisfaction, decreased nutritional intake in 115 residents out of 120 residents and increased risk for choking for 41 residents receiving a mechanical soft and 7 residents receiving a pureed diet. Findings: During a review of the facility's Lunch Menu on 1/27/2025, the menu indicated the following items would be served. 1. Regular diet: Pot roast with Gravy (3 ounces(oz.); Buttered new potatoes #12 scoop (yielding 1/3 cups); Baby Carrots 4 oz.; Bread roll with margarine; Chocolate yogurt mousse and milk. 2. Mechanical soft diet: Ground pot roast with gravy (3 oz.); Chopped buttered new potatoes 1/3 cup; Chopped baby carrots 4oz.; Bread roll with margarine; Chocolate yogurt mousse and milk. 3. Puree diet: Pureed pot roast 1/2 cup; Pureed buttered new potatoes 1/2 cup; Pureed baby carrots 1/3 cup; Pureed bread with margarine; Chocolate yogurt mousse and milk. During an observation of the tray line service for lunch (a system of food preparation, in which trays move along an assembly line) on 1/27/2025, at 12:05 p.m., observed the cook (Cook 1) serve mashed potatoes instead of buttered new potatoes. The desert was vanilla pudding instead of chocolate yogurt mousse. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with [NAME] 1 and the Assistant Dietary Supervisor (ADS) on 1/27/2025 at 12:15 p.m., [NAME] 1 stated that she was per diem (non-full time employee) and was here for assistance on 1/27/2025 because the regular cook was not there. [NAME] 1 stated she looked at the menu and new potatoes were not available. [NAME] 1 stated there was also no chocolate powder or yogurt to make the chocolate yogurt mousse for dessert. The ADS stated the facility did not have red potatoes to make the buttered new potatoes for lunch and did not have the yogurt and chocolate powder to make the dessert on 1/27/2025. The ADS stated the products were not delivered and the menu had to be adjusted. The ADS stated she documented the change on the menu change log and was awaiting signature and approval from the RD. During an interview with the DS on 1/27/2025 at 1:30 p.m., the DS stated the facility did not receive the deliveries for the potatoes and the chocolate powder. During a dining observation on 1/28/2025 at 8:30 a.m., a resident (Resident 70) was observed complaining that the breakfast was not the same as indicated in the menu. Resident 70 complained the facility did not serve waffles and grits that morning (1/28/2025) During an interview with [NAME] 2 on 1/28/2025 at 9:00 a.m., [NAME] 2 stated the breakfast served that morning (1/28/2025) were omelets and toast because the facility did not have waffles and grits. During an interview with the ADS and DS on 1/28/2025 at 12:15 p.m., the ADS stated lately the facility was not getting some of the ingredients to make the correct food items. The ADS stated the cooks often substitute. The ADS stated she did not inform the residents of the menu changes because it was last minute, and the dietary staff were in a rush. The DS stated she knew when residents did not receive the food items indicated on the menu the residents could be upset and not eat the food. The DS stated the dietary staff should let the residents know of changes to the menu. The DS stated the food ordering system was through a 3rd party company which handled the facility's orders and sometimes there was a delay in the deliveries. The DS stated lately there had been more delays in the food deliveries. During an interview with the RD on 1/28/2025 at 4:00 p.m., the RD stated she had no idea about items missing from the menu and the changes to the menu. The RD stated the food item changes would upset the residents and decrease meal satisfaction. The RD stated she did not know there was a problem with food deliveries. During an interview with the Administrator (ADM) on 1/29/2025 at 3:00 p.m., the ADM acknowledged the problems with the food delivery company and stated when residents did not receive the food items indicated on the menu, the residents could become upset. During a review of the facility policy and procedure (P&P) titled Menus (revised 10/2008), the P&P indicated, Menus shall a. meet the nutritional needs of residents; b.be prepared in advanced and c. be followed .The dietitian will review and approve all menus. 2. During an observation with [NAME] 1 on 1/27/2025 at 12:05 p.m., of the tray line service for lunch, observed that the mechanical soft pork pot roast was shredded with long and thick pieces. The pureed bread was thin and watery with brown lumps. When [NAME] 1 served the pureed bread, it spread thinly over the plate. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview with [NAME] 1 on 1/27/2025 at 12:15 p.m., [NAME] 1 stated that she was per diem and was here for assistance because the regular cook was not there. [NAME] 1 stated the pork pot roast was blended in the food processor to a shredded consistency. [NAME] 1 stated residents did not like when the pork pot roast was chopped into smaller pieces. During a concurrent interview and record review with [NAME] 1 on 1/27/2025 at 12:15 p.m., the menu and spreadsheet (food portion and serving guide) was reviewed. [NAME] 1 stated she made a mistake because the pork pot roast served to residents on a mechanical soft diet should be ground and not shredded. [NAME] 1 agreed that some of the shredded pieces of the pork pot roast were large and it was not appropriate for some residents. [NAME] 1 stated this could make the residents have problems with swallowing and risk for choking. [NAME] 1 stated the pureed bread was regular bread soaked in lactose free milk and melted margarine then slightly blended. [NAME] 1 stated the texture of the puree bread was thin and watery and not a pudding like consistency. [NAME] 1 stated the incorrect consistency of the bread could result in the residents choking. During an interview with the ADS on 1/27/2025 at 12:20 p.m., the ADS stated the pork roast for the mechanical soft diet should be ground. The ADS stated ground looked like hamburger meat. The ADS sated the pork pot roast should be blended in the food processor longer so it was smaller in size. During an interview with the DS on 1/27/2025 at 1:30 p.m., the DS stated the pork pot roast should be ground and not shredded. The DS stated the residents on a mechanical soft diet received a texture that was not consistent with the menu, which could result in some residents having a hard time eating, chewing and swallowing the food. During an interview with the RD on 1/28/2025 at 4:00p.m., the RD stated cooks should always follow the menu and recipe. During a review of the facility's policy and procedure (P&P) titled Mechanical Soft (ground) (revised 4/2024), the P&P indicated, Diet that requires a reduced amount of chewing. For residents who have limited chewing ability and intact swallowing ability . All meats (such as beef, fish, poultry and pork) should be ground or chopped. Gravy or sauces should be added to moisten dry ground and chopped meats, poultry and fish. Chopped: 1/4- 1/2 pieces; Ground: 1/8 or less-consistency of ground meat. During a review of the facility's P&P titled Puree (revised 4/2024), the P&P indicated, Food texture prepared lump-free, not firm or sticky and holds it shape on a plate. The diet requires no biting or chewing. Any liquids must not separate from the food and the food can fall of a spoon intact. The food is more easily swallowed and prevents aspiration. During a review of the Pot Roast Recipe indicated for mechanical soft texture, the recipe indicated to grind portions needed from the regular prepared recipe and serve with gravy.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 38740 Based on observation, interview, and record review, the facility failed to ensure that food was prepared by methods that conserved flavor and served at appetizing temperatures for 115 out of 120 residents who received food from kitchen and for Resident 70, who complained the food did not match the menu and was cold. These deficient practices had the potential to result in meal dissatisfaction, decreased food intake and placed residents at risk for unplanned weight loss. Findings: During the initial facility tour on 1/27/2025 at 8:00 a.m., complaints about the temperature and flavor of food were identified. Complaints about the flavor and temperature of food were also discussed during a resident council meeting held on 1/28/2025 at 10:50 a.m. During a concurrent observation and interview with [NAME] 2 on 1/28/2025 at 12:00 p.m., in the kitchen, [NAME] 2 was observed assembling the trays on the steamtable to begin the lunch service. [NAME] 2 stated on that morning (1/28/2025) the facility did not serve the grits and waffles per the menu because the food items were not in stock. [NAME] 2 stated for lunch, the facility was serving pork chops with gravy, red beans and rice, coleslaw and a biscuit. During a concurrent observation and interview with [NAME] 2, Assistant Dietary Supervisor (ADS), and the Dietary Supervisor on 1/28/2025 at 12:11 p.m., in the kitchen, [NAME] 2 was observed checking the temperature of the lunch items using the facility's thermometer. The temperature of food checked were as follows: 1. Pureed Bread - 150 degrees Fahrenheit (F, unit of temperature). 2. Pureed Pork chops - 175 degrees F. 3. Puree [NAME] and beans - 190 degrees F. 4. Pureed cabbage (instead of coleslaw) - 165 degrees F. 5. Regular/mechanical soft (a modified diet that consists of soft, easily chewed foods that can be safely swallowed by individuals with difficulty chewing or swallowing) rice and beans - 175 degrees F. 6. Mechanical soft pork chops - 187 degrees F. 7. Regular Pork chops - 151 degrees F. 8. Gravy - 151 degrees F. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the same observation and interview, the ADS stated the facility was serving food for 115 residents. The ADS stated residents in the dining room were served food first. The ADS stated sometimes the food assembly and process was interrupted and delayed because dietary staff must wait until they were informed of the residents present in the dining room. During a dining observation on 1/28/2025 at 1:20 p.m., observed Resident 70 dining inside his room. Resident 70 was observed complaining that the pork chops served for lunch were cold. During the test tray on 1/28/2026 at 1:35 p.m., food temperatures of sampled food varied from warm to lukewarm. The DS took temperatures of the test tray items using the facility's thermometer which recorded as follows: 1. [NAME] and beans - 134 degrees F. 2. Pork chop and gravy 108 degrees F. 3. Mechanical soft pork chop 109 degrees F. 4. Pureed pork chop - 109 degrees F. 5. Pureed rice and beans - 99 degrees F. 6. Pureed Vegetables - 96 degrees F. During the same test tray, the DS stated the pork chop was cold. The DS stated the trays were sitting in the cart for too long before they were served and there was a temperature drop. The DS stated the food should be higher than 100 degrees F during service, but the pureed rice and beans and vegetables were below 100 degrees F. The DS stated the temperature of the pork chops and gravy was lower than the other food items in the kitchen and should be higher to maintain the temperature during meal service.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on observation, interview, and record review, the facility failed to ensure mechanically altered diets (a diet consisting of foods and liquids that have been prepared to be easier to chew and/or swallow) were prepared, provided, and served as ordered for four of eight sampled residents (Resident 11, Resident 99, Resident 5 and Resident 82). This deficient practice had the potential to result in aspiration (when food, liquid, or other material enters a person's airway and eventually the lungs by accident) and complications of aspiration, such as pneumonia (an infection/inflammation in the lungs) and/or inability to breathe. Findings: 1. During a review of Resident 11's Admission Record, the Admission Record indicated Resident 11 was originally admitted on [DATE] and was most recently readmitted on [DATE]. Resident 11's admitting diagnoses included dysphagia (difficulty swallowing), metabolic encephalopathy (a problem in the brain caused by chemical imbalances in the blood), generalized muscle weakness, and lack of coordination. During a review of Resident 11's Minimum Data Set (MDS, a resident assessment tool), dated 11/4/2025, the MDS indicated Resident 11 had severe cognitive impairments (a significant decline in cognitive abilities that interferes with daily life and independence). The MDS indicated Resident 11 could eat independently once a meal was placed in front of him. The MDS indicated Resident 11 required a mechanically altered diet. During a review of Resident 11's diet order, dated 6/27/2024, the diet order indicated Resident 11 was to have a mechanical soft, finely chopped diet (a diet consisting of foods that are ground, chopped, or mashed to make them easier to swallow). During a review of Resident 11's care plan titled Nutritional problem or potential nutritional problem ., dated 12/22/2021, the care plan interventions indicated staff were to provide Resident 11's diet a mechanical soft, finely chopped diet, as ordered. During an observation on 1/27/2025 at 9:22 a.m., Resident 11's breakfast tray was observed. Resident 11 had a piece of toasted bread, cut in half diagonally, and an omelet (a dish of beaten eggs cooked in a frying pan until firm). During an observation on 1/27/2025 at 9:24 a.m., an unidentified staff placed Resident 11's breakfast tray in front of the resident and cut the omelet into one-inch pieces. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview, on 1/27/2025 at 9:29 a.m., with Certified Nursing Assistant (CNA) 1, Resident 11's breakfast tray and tray ticket were observed. CNA 1 stated Resident 11's tray ticket (a slip of paper that displays exactly what that resident will be receiving, based on the resident's diet order and food preferences) indicated Resident 11 was to receive a mechanical soft, finely chopped tray. CNA 1 stated the pieces of toasted bread, and the pieces of omelet were not mechanical soft and finely chopped. During an observation on 1/27/2025 at 1:36 p.m., Resident 11 was observed eating lunch in the hallway without staff assistance. Resident 11's lunch tray and tray ticket were observed, and the tray ticket indicated Resident 11 was to have a mechanical soft, finely chopped tray. Resident 11 had an uncut bread roll on the tray. During an observation on 1/28/2025 at 1:37 p.m., of Resident 11 was observed eating lunch in the hallway without staff assistance. Resident 11's lunch tray and tray ticket were observed, and the tray ticket indicated Resident 11 was to have a mechanical soft, finely chopped tray. Resident 11 had a dessert, and the dessert pieces were larger than 1/8-inch to 1/4-inch in size. During a concurrent observation and interview, on 01/29/2025 at 12:01 p.m., with the Speech Therapist (ST), photos of Resident 11's breakfast and lunch taken on 1/27/2025, and lunch on taken 1/28/2025, were observed. The ST stated the slices of toast provided for breakfast on 1/27/2025 and the bread roll provided at lunch on 1/27/2025 should not have been served for a mechanical soft, finely chopped diet. The ST stated the dessert provided on 1/28/2025 included pieces that were too large to be served for a mechanical soft, finely chopped diet. The ST stated there was potential for Resident 11 to aspirate if the food pieces were not mechanical soft in texture and finely chopped in size. 2. During a review of Resident 99's Admission Record, the Admission Record indicated Resident 99 was originally admitted on [DATE] and was most recently readmitted on [DATE]. Resident 99's admitting diagnoses included generalized muscle weakness, iron deficiency anemia (a condition where the body does not have enough iron to produce healthy red blood cells), vitamin B-12 deficiency anemia (a condition where the body doesn't have enough healthy red blood cells due to a lack of vitamin B12), and adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 99's MDS, dated [DATE], the MDS indicated Resident 99 did not have cognitive impairments. The MDS indicated Resident 99 was dependent on staff to eat and required a mechanically altered diet. During a review of Resident 99's diet order, dated 11/7/2024, the diet order indicated Resident 99 was to receive a mechanical soft texture diet. During a concurrent observation and interview, on 1/28/2025 at 1:43 p.m., at Resident 99's bedside, CNA 2 was observed providing Resident 99 a bean and cheese burrito, that was not cut into pieces, and had toasted, crispy, browned edges. CNA 2 stated she requested this substitute because Resident 99 liked Mexican food. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview, on 01/29/2025 at 12:01 p.m., with the Speech Therapist (ST), a photo of Resident 99's lunch taken on 1/28/2025 was observed. The ST stated mechanical soft foods were supposed to be easy to chew and swallow, and stated the tortilla of Resident 99's burrito should not have been toasted. The ST stated the tortilla should have been served untoasted because it would be a softer texture and easier for Resident 99 to chew. The ST stated that the bean and cheese burrito served on 1/28/2025 was an aspiration hazard. During a review of the facility's policy and procedure (P&P) titled Mechanical Soft, revised 4/2024, the P&P indicated a mechanical soft diet required a reduced amount of chewing and should be individualized according to a resident's ability to chew and swallow. The P&P indicated that for a mechanical soft, finely chopped diet, the food should be cut into pieces 1/8-inch to 1/4-inch in size. 45009 3. During an observation on 1/28/2025 at 8:07 a.m., in Resident 5's room, Resident 5 was observed eating breakfast. Resident 5's food items was not pureed. During an observation on 1/29/2025 at 7:49 a.m., in Resident 5's room, Resident 5 was observed eating breakfast. Resident 5's food items was not pureed. During a review of Resident 5's Admission Record, the admission record indicated Resident 5 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 5's diagnoses included dysphagia and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). During a review of Resident 5's History and Physical (H&P) dated 7/2/2024, the H&P indicated Resident 5 had fluctuating capacity to understand and make decisions. During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 5 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistant as resident completes activity) for eating. The MDS indicated Resident 5 required maximal assistance (helper does more than half the effort) for showering/bathing, lower body dressing and personal hygiene. During a review of Resident 5's Order Summary Report, dated 9/23/3034, the order summary report indicated Resident 5 was to receive with a pureed texture (a very smooth, crushed or blended food), thin liquid consistency diet. During a review of Resident 5's Care Plan for Nutrition, dated 3/12/2019, the care plan indicated Resident 5's goal was to consume 75-100 percent (%) of the meal. The care plan intervention's indicated to provide Resident 5 with a pureed texture and a thin liquid consistency diet. During an interview on 1/29/2025 at 7:53 a.m. with Resident 5, Resident 5 stated he did not receive his food pureed that day (1/29/2025). Resident 5 stated he was supposed to have his food pureed but the meat was cut into small pieces. Resident 5 stated he usually swallowed his food without chewing but with this meal he had to chew it. Resident 5 stated he preferred his food to be pureed. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/31/2025 at 9:41 a.m. with the Dietary Supervisor (DS), the DS stated residents with swallowing issues, have no teeth, or have difficulty chewing received a pureed diet. The DS stated if that resident did not receive a pureed meal there was a risk for choking and it would be difficult for the resident to eat. The DS stated it was important for a resident to receive the appropriate food texture for the resident's safety while eating and for residents to be able to eat. The DS reviewed the pictures of Resident 5 meal on 1/29/2025 and stated the resident's food was not pureed and instead it was a mechanical soft (consists of any foods that can be blended, mashed, pureed, or chopped) texture. The DS stated the food in the picture looked lumpy and it was not recommended for a resident that was on a pureed diet. 4. During a review of Resident 82's Admission Record, the admission record indicated Resident 82 was admitted to the facility on [DATE]. Resident 82's diagnoses included myalgia (pain in a muscle or group of muscle) and left lower leg fracture (complete or partial break in the bone). During a review of Resident 82's H&P dated 10/13/2024, the H&P indicated Resident 82 had the capacity to understand and make decisions. During a review of Resident 82's MDS, dated [DATE], the MDS indicated Resident 82's cognitive skills were intact. The MDS indicated Resident 82 was independent for all activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 82's Nutritional update, dated 7/24/2023, the nutritional update indicated Resident 82 was to receive a regular diet and a mechanical soft texture for all meals. The nutritional update indicated to provide Resident 82 with small portion meals at dinner time to prevent further weight gain. During a review of Resident 82's Nutritional update, dated 10/22/2024, the nutritional update indicated Resident 82 was to receive a regular diet and a mechanical soft texture for all meals. The nutritional update did not indicate to serve small portions at dinner to Resident 82. During a review of Resident 82's electronic medical record (EMR), dated 1/2025, unable to locate doctors' order indicating to serve small portions to Resident 82 for dinner. During an interview on 1/29/2025 at 8:09 a.m. with Resident 82, Resident 82 stated he received small portions for dinner. Resident 82 stated he saw other residents had more food on their plate than what he had on his plate. Resident 82 stated he did not know why his portion was so small and stated that maybe it was because the facility did not have enough food. Resident 82 stated staff did not inform him why he was receiving smaller portions. Resident 82 stated he was always hungry during breakfast time because his dinner was very small. During a concurrent interview and record review on 1/30/2025 at 9:53 a.m. with the DS, Resident 82's Doctor Orders, dated 1/2025 was reviewed. The Doctor Orders indicated Resident 82 did not have an order for small meal portions for dinner. The DS stated he was not informed the doctor discontinued the smaller meal portions for Resident 82. The DS stated Resident 82 was placed on small dinner portions because the resident gained weight. The DS stated staff should have informed him (DS) when the small portion order was discontinued. The DS stated Resident 82 should not receive small food portions for dinner if there was no order for small dinner portions. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled Diet Orders, dated 2023, the P&P indicated diet orders as prescribed by the physician would be provided by the food and nutrition services department. The P&P indicated nursing would send a Diet Order Communication slip to the food and nutrition services department. The food and nutrition services director would make or adjust the diet profile and tray card as prescribed. During a review of the facility's P&P titled Dysphagia Diets, dated 4/2024, the P&P indicated for dysphagia management, food texture must be prepared lump free, not firm or sticky and holds its shape on a plate. The P&P indicated this diet required no biting or chewing. The P&P indicated this type of food was more easily swallowed and prevented aspiration. The P&P indicated puree foods should have a pudding like smooth consistency without lumps (in example, sour cream or mayonnaise thickness/moistness).

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on observation, interview, and record review, the facility failed to ensure a preference for a Magic Cup (a frozen dessert used for providing additional calories and protein to those experiencing involuntary weight loss) was provided with meals, for one of five sampled residents (Resident 11). This deficient practice had the potential to result in decreased meal intake and could lead to weight loss and malnutrition. Findings: During a review of Resident 11's Admission Record, the Admission Record indicated Resident 11 was originally admitted on [DATE] and was most recently readmitted on [DATE]. Resident 11's admitting diagnoses included metabolic encephalopathy (a problem in the brain caused by chemical imbalances in the blood), type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), and dysphagia (difficulty swallowing). During a review of Resident 11's Minimum Data Set (MDS, a resident assessment tool), dated 11/4/2025, the MDS indicated Resident 11 had severe cognitive impairments (a significant decline in cognitive abilities that interferes with daily life and independence). The MDS indicated Resident 11 could eat independently once a meal was placed in front of him. The MDS indicated Resident 11 required supervision or touch assistance from staff for mobility while in and out of bed. During a review of Resident 11's diet order, dated 6/27/2024, the diet order indicated Resident 11 was to have a Magic Cup three times a day with meals. During a review of Resident 11's care plan titled Nutritional problem or potential nutritional problem ., dated 12/22/2021, the care plan goals indicated Resident 11 would achieve a goal weight of 177 pounds. Care plan interventions indicated staff were to provide Resident 11's diet as ordered. During a concurrent observation and interview, on 1/27/2025 at 9:29 a.m., with Certified Nursing Assistant (CNA) 1, Resident 11's breakfast tray and tray ticket were observed. CNA 1 stated Resident 11's tray ticket (a slip of paper that displays exactly what that resident will be receiving, based on the resident's diet order and food preferences) indicated Resident 11 was to receive a Magic Cup. CNA 1 stated Resident 11's breakfast tray did not have a Magic Cup on it. During an observation on 1/27/2025 at 1:36 p.m., of Resident 11's lunch tray and tray ticket, the tray ticket indicated Resident 11 was to have a Magic Cup. No magic cup was observed on the tray. During an observation on 1/28/2025 at 1:37 p.m., of Resident 11's lunch tray and tray ticket, the tray ticket indicated Resident 11 was to have a Magic Cup. No magic cup was observed on the tray. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review, on 1/28/2025 at 3:39 p.m., with the Dietary Supervisor (DS), Resident 11's diet order and food preferences were reviewed. The DS stated Resident 11's food preferences indicated he preferred to have a Magic Cup three times a day with meals, and stated this was reflected in Resident 11's diet order. The DS stated the facility had Magic Cup in stock and stated that if the resident had a preference to have it with meals, and it was indicated in their diet order, it should be provided to the resident. During a review of the facility's policy and procedure (P&P) titled Resident Food Preferences, revised 11/2018, the P&P indicated the resident's preferences were to be documented in the clinical record, and stated staff were to accommodate those preferences.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009 During an observation, interview, and record review, the facility failed to provide an assisted device during mealtime for one resident out of eight sampled residents (Resident 5) by: 1. Not ensuring Resident 5 received a plate guard during his mealtime. 2. Not ensuring dietary staff and nursing staff checked Resident 5's food tray for a plate guard. These deficient practices made it difficult for Resident 5 to feed himself and made Resident 5 feel upset about his food spilling over his plate. Findings: During an observation on 1/27/2025 at 1:15 p.m., in Resident 5's room, Resident 5 was observed sitting in bed eating lunch. Resident 5's food slip indicated to receive a plate guard for all meals. Resident 5 did not have a plate guard attached to his plate. Resident 5's food spilled over the plate when he spooned his food. During an observation on 1/28/2025 at 8:02 a.m., in Resident 5's room, Resident 5 was observed sitting on his bed eating breakfast. Resident 5 was spooning his food to the edge of the plate as the food spilled over the plate. During an observation on 1/28/2025 at 1:44 p.m., in Resident 5's room, Resident 5 was observed sitting on his bed eating lunch. Resident 5 was spooning his food to the edge of the plate as the food spilled over the plate. During a review of Resident 5's Admission Record, the admission record indicated Resident 5 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 5's diagnoses included dysphagia (difficulty swallowing) and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). During a review of Resident 5's History and Physical (H&P) dated 7/2/2024, the H&P indicated Resident 5 had fluctuating capacity to understand and make decisions. During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool), dated 11/7/2024, the MDS indicated Resident 5's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was moderately impaired. The MDS indicated Resident 5 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistant as resident completes activity) for eating. The MDS indicated Resident 5 required maximal assistance (helper does more than half the effort) for showering/bathing, lower body dressing and personal hygiene. During a review of Resident 5's Order Summary Report, dated 9/23/3034, the order summary report indicated Resident 5 was to receive a plate guard at breakfast, lunch, and dinner. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 5's Care Plan for nutrition, dated 3/12/2019, the care plan indicated Resident 5's goal was to consume 75-100 percent (%) of meals. The staff's interventions indicated to provide Resident 5 with a plate guard during breakfast, lunch and dinner. During a review of Resident 5's Nutritional Update, dated 5/9/2024, the nutritional update indicated Resident 5 was to receive a plate guard at breakfast, lunch, and dinner. During an interview on 1/27/2025 at 1:19 p.m. with Resident 5, Resident 5 stated he used to get a plate guard with his meals a long time ago. Resident 5 stated it was hard for him to eat without the plate guard because he spills his food over his plate and he feels frustrated. Resident 5 stated he would like a plate guard to help him during his meals. During an interview on 1/29/20245 at 7:52 a.m. with Resident 5, Resident 5 stated it was easier to eat that day (1/29/2025) because he had a plate guard. Resident 5 stated he benefited from the plate guard because he did not spill or waste his food. During an interview on 1/30/2025 at 9:26 a.m. with the Dietary Supervisor (DS), the DS stated a plate guard served to help residents eat. The DS stated residents that are unable to feed themselves easily need a plate guard. The DS stated if a resident did not receive a plate guard, they could spill their food and eat less of their meal. The DS stated it was important for a resident to use a plate guard to promote independent eating. The DS stated Resident 5 must receive a plate guard for all meals and did not understand why he was not getting one. During a concurrent observation and interview on 1/31/2025 at 7:38 a.m. with the DS, in Resident 5's room, Resident 5 was observed without a plate guard on his food tray. The DS stated Resident 5 should have a plate guard to assist him with feeding himself. The DS stated his staff checked the food trays that required a plate guard and they all had plate guards and most likely nursing staff removed it from the food tray. During an interview on 1/31/2025 at 7:43 a.m. with Certified Nursing Assistant (CNA) 6, CNA 6 stated she gave Resident 5 his breakfast tray (on 1/31/2025). CNA 6 stated the plate guard was the plate Resident 6 was eating off. CNA 6 did not answer whether or not she knew what a plate guard was. During an interview on 1/31/2025 at 7:56 a.m. with Licensed Vocational Nurse (LVN) 5, LVN 5 stated food trays should be checked by a licensed nurse and a CNA before passing the food tray to a resident. LVN 5 stated nursing staff must check if the resident received the correct diet, food texture, and assisted devices. LVN 5 stated it was everyone's responsibility to check if everything on the food tray was correct. LVN 5 stated a plate guard should have been on Resident 5's food tray. LVN 5 stated CNA 6 should have made sure there was a plate guard on Resident 5's food tray and if there was not one, CNA 6 should have requested one from the kitchen. During a review of the facility's Policy and Procedure (P&P) titled Quality of Life- Accommodation of Needs dated 2009, the P&P indicated residents individual needs and preferences would be accommodated to the extent possible. The P&P indicated in order to accommodate individual needs and preferences, staff attitudes and behaviors must be directed towards assisting the residents in maintaining independence, dignity and well-being to the extent possible and in accordance with resident wishes. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled Commonly Used Self-Feeding Devices, dated 2023, the P&P indicated a plate guard was a stainless steel or plastic ring that attaches to the edge of the plate to prevent food from spilling off the edge. The P&P indicated the resident is able to gather food on a spoon by pushing the spoon against the edge of the plate. The P&P indicated a plate guard was used for the residents who have any condition resulting in weakness or poor coordination, impaired vision, or use od only one hand.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38740 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: 1. Nutritional supplements labeled store frozen with manufacturers instruction to use within 14 days of thawing, were not monitored for the date they were thawed to ensure expired shakes were discarded after this time frame. Two boxes of unpasteurized shell eggs were stored in the facility walk-in refrigerator. Residents received fried eggs with unpasteurized shell eggs. One bag of breakfast pork sausage open [DATE] stored in the walk-in refrigerator exceeding storage period for pork sausage. One large pot containing cooked turkey soup stored in the walk-in refrigerator with no date. One open bag of pasta with use by date of [DATE] expired and stored in the dry storage room. 2. Kitchen equipment and work area were not maintained in a clean manner to prevent the potential harborage of pests and the growth of microorganisms (germs). The oven and range had dried food debris, the side of the oven had dried spills food stains, the wall behind the range was stained and dirty, and the steam table knobs had dried food debris. 3. Resident food brought from outside of the facility, including leftovers, were stored in the resident refrigerator located in the ice machine room with no dates or were expired. These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to food borne illness in 115 out of 120 residents who received food from the facility, and 14 residents who received nutritional supplements including residents who had food stored in the resident refrigerator. Findings: 1a. During a concurrent observation and interview with the Assistant Dietary Supervisor (ADS), in the kitchen, on [DATE] at 8:30 a.m., there was one large plastic container with 30 individual serving cartons of strawberry flavored nutrition supplement and another large plastic container with 15 individual serving cartons of chocolate flavored nutrition supplement observed stored in the walk-in refrigerator with no thaw date. The ADS stated the nutrition supplements were delivered frozen then were either stored in the freezer or when there was no space in the freezer the boxes were directly stored inside the refrigerator where they were thawed. The ADS sated the date on the containers were not the thaw date. The ADS did not know when the nutritional supplements in the walk-in refrigerator were thawed. During an interview with the Dietary Supervisor (DS) on [DATE] 1:30 p.m., the DS stated once thawed the shakes were good for 14 days. The DS stated when the shakes were in the fridge, the shakes needed to be monitored for thaw date and use by date to allow staff to identify when the product has expired. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1b. During a concurrent observation and interview with the ADS, on [DATE] at 9:20 a.m., in the kitchen, there were two boxes of raw shell eggs observed stored in the facility walk-in refrigerators. The shell eggs were not pasteurized (pasteurized eggs- are eggs that received heat treatment to make it safe for consumption and reduce risk of food borne illness in dished that are lightly cooked). The ADS stated facility served scrambled eggs using liquid eggs that morning ([DATE]). The ADS stated she cooked fried eggs for 24 residents who only want fried eggs, and most of them ask for not well-done eggs. The ADS stated the residents like the eggs lightly cooked and the dietary staff used pasteurized eggs for the fried or hard-boiled eggs. The ADS pointed to the shell eggs that were not pasteurized and stated the eggs were used for the fried eggs. The ADS did not know that they were not pasteurized eggs. During an interview with the DS on [DATE] at 1:30 p.m., the DS stated he ordered pasteurized eggs and was surprised to receive the two boxes of Pasture Raised eggs instead of pasteurized (Pasture-raised eggs come from [NAME] that have access to la large outdoor space, called a pasture, there they can roam.) The DS stated unpasteurized eggs have the potential for salmonella contamination and can make residents sick. DS stated pasture-raised eggs are not pasteurized and can be potential risk for salmonella (common bacterial disease that affects the intestinal tract). During a review of the facility's policy and procedure (P&P) titled Food Preparation and Service (undated) indicated, Only pasteurized shell eggs will be cooked and served when: a. residents request undercooked, soft-served or sunny side up eggs and preparing foods that will not be thoroughly cooked. Unpasteurized eggs will be cooked until all parts of the egg (yolk and whites) are completely firm. During a review of the 2022 U.S. Food and Drug Administration Food Code titled Eggs and Milk Products, Pasteurized. Code ,d+[DATE].14 indicated, (A) Egg products shall be obtained pasteurized. 1c. During an observation in the kitchen on [DATE] at 8:35 a.m. there was one bag of breakfast pork sausages dated [DATE] stored in the walk-in refrigerator. During the same observation there was one large pot of turkey broth covered with solid fat stored in the walk-in refrigerator with no date. During a concurrent observation and interview with the ADS on [DATE] at 8:35 a.m., the ADS stated the frozen pork sausage was stored more than 5 days and should be discarded. The ADS stated she did not know why the turkey broth was stored in the refrigerator and with no date. The ADS was observed discarding the sausages and the pot with turkey broth. During a concurrent observation and interview with the ADS, on [DATE] at 8:40 a.m., , in the dry storage area, there was one open package of pasta with dates ,d+[DATE] and use by date [DATE], exceeding the storage period for the pasta. The ADS stated the pasta was over the use by date and should be discarded. During a review of the facility's P&P titled, Refrigerators and Freezers (Revised ,d+[DATE]), the P&P indicated, All food shall be appropriately dated to ensure proper rotation by expiration dates. The P&P indicated supervisors will be responsible for ensuring food items in pantry, refrigerators and freezers are not expired or past perish dates. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Food Receiving and Storage (revised ,d+[DATE]), the P&P indicated, All food stored in the refrigerator or freezer will be covered, labeled and dated (use by date). During a review of the facility's refrigerated Storage guide, the guide indicated meat taken from the freezer to thaw for luncheon meats and other processed meats is 5 days. During a review of the 2022 U.S. Food and Drug Administration Food Code titled Ready to Eat, Time/Temperature control for safety food, Date Marking Code#,d+[DATE].17, the document indicated, Ready to eat, time temperature control for safety food prepared and packaged by food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed, sold, or discarded. 2. During a concurrent observation and interview with the ADS, on [DATE], at 10:00 a.m., in the kitchen food preparation and service area, the range (stove and oven) and steamtable were observed. The stove top had dried and burnt food debris, the side of the oven was sticky and stained of spillage. The oven doors and handles had dried food debris stuck on them, the tiles of the wall behind the oven had stains and build up. The steam table burner knobs had dried food debris and stains on them. The ADS stated that there was a cleaning schedule and the cook should clean the stove, oven and steamtable every day. The ADS stated there was a cleaning log but the stove, oven, and steamtable were not cleaned that day ([DATE]) because the cook called in sick. During a concurrent interview and record review with the DS, on [DATE] at 1:30 p.m., the Cleaning Schedule was reviewed. The Cleaning Schedule indicated the cleaning of the oven, range and burners were done daily. The DS stated the cleaning of the oven was done once a week. The DS verified that the schedule needed to be clarified. The DS also stated that the oven, range and steamtable were dirty and dirty areas had the potential to attract pests to the kitchen. During an interview with the Registered Dietitian (RD) on [DATE] at 4:00 p.m., the RD stated she does monthly infection control audits in the kitchen and noticed that the kitchen had dried food debris and stains. The RD stated she discusses her findings with the Dietary Supervisor and Adminstrator. During an interview with the Administrator (ADM) on [DATE] at 3:00 p.m., the ADM stated an outside cleaning company was hired to provide deep cleaning services in the kitchen and the service had been delayed. The ADM stated the kitchen should be cleaned of dust and food debris. During a review of the 2022 U.S. Food and Drug Administration Food Code titled Nonfood-contact Surfaces Code ,d+[DATE].13, the document indicated, The presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment of the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents, and other pests. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a concurrent observation and interview with the ADS on [DATE] at 10:35 a.m., in the Resident Refrigerator located in the Ice Machine Room, observed one paper bag containing left-over food from a fast-food restaurant dated [DATE]. Observed another paper bag containing food for a resident dated [DATE] stored in the resident refrigerator. There was a carton of one dozen shell eggs stored in the freezer with date of [DATE]. The ADS stated dietary staff was responsible for monitoring the expiration dates of the food and discard from the refrigerator. The ADS stated resident outside food was stored for 3 days then they were discarded. The ADS stated residents should not eat the leftovers that exceeded the use by date because they could get sick. During a review of the facility's P&P titled Foods Brought by Family/Visitors (revised ,d+[DATE]) the P&P indicated, The dietary staff is responsible for discarding perishable foods on or before the use by date.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009 Based on interview and record review, the facility failed to ensure the registered nurses (RN) accurately documented the medication administration and monitoring of Meropenem (used to treat a wide variety of bacterial infections) for one out of eight sampled residents (Resident 155) by failing to: These deficient practices resulted in Resident 115's missed administration and incomplete assessments of the resident's intravenous (through the vein) administration site that would potentially cause a delay in care and placed Resident 115 at risk of developing an antibiotic-resistant infection. Findings: During a review of Resident 115's Admission Record, the admission record indicated Resident 115 was admitted to the facility on [DATE] with diagnoses including abscess (swollen area within body tissue, containing an accumulation of pus) of the prostate (a gland in the male reproductive system) and diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 115's History and Physical (H&P) dated 1/10/2025, the H&P indicated Resident 115 had the capacity to understand and make decisions. During a review of Resident 115's Minimum Data Set (MDS, a resident assessment tool), dated 1/19/2024, the MDS indicated Resident 115's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was intact. The MDS indicated Resident 115 was independent for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 115's Order Summary Report, dated 1/7/2025, the order summary report indicated an order for Meropenem 1 gram ([gm] metric unit of measurement, used for medication dosage and/or amount) for prostate abscess, intravenously (IV, through the vein) every eight hours, at 6 a.m., 2 p.m. , and 10 p.m., until 2/4/2025. The order summary report indicated the order was discontinued on 1/25/2025. During a review of Resident 115's Order Summary Report, dated 1/7/2025, the order summary report indicated to check Resident 115's IV site for redness, pain at the insertion site, swelling, infiltration (intravenous fluids accidentally leak out of the vein and into the surrounding tissue), phlebitis (inflammation of a vein near the surface of the skin), adverse reaction to infusion (method of putting fluids, or drugs into the bloodstream). The order summary report indicated to ensure the IV device is intact and saline flush (a mixture of salt and water that is used to push any residual medication or fluid through the IV line and into your vein) every eight hours before and after medication administration. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 115's Order Summary Report, dated 1/25/2025, the order summary report indicated an order for Meropenem 1 gm for prostate abscess, intravenously every eight hours, at 2 a.m., 10 a.m., and 6 p.m., until 2/4/2025. The order summary report indicated the order was discontinued on 1/27/2025. During a review of Resident 115's Order Summary Report, dated 1/27/2025, the order summary report indicated an order for Meropenem 1 gm for prostate abscess, intravenously every eight hours, at 6 a.m., 2 p.m., and 10 p.m., until 2/4/2025. During a review of Resident 115's Medication Administration Record (MAR), for the month of January 2025, the MAR indicated Resident 115 did not receive Meropenem on the following dates and times: 1/8/2025 at 2 p.m., 1/9/2025 at 2 p.m. and 10 p.m., 1/10/2025 at 2 p.m., 1/11/2025 at 6 a.m., 1/12/2025 at 6 a.m., 1/13/2025 at 2 p.m., 1/15/2025 at 10 p.m., 1/17/2025 at 6 a.m., 1/20/2025 10 p.m., 1/21/2025 at 6 a.m., 1/22/2024 at 10 p.m., 1/25/2025 at 6 a.m., 1/27/2025 at 2 a.m., 1/29/2025 at 10 p.m., and 1/30/2025 at 10 p.m. During a review of Resident 115's electronic medical record, unable to locate nursing progress notes that indicated the reason why Resident 115 did not receive Meropenem on 1/27/2025. During a review of Resident 115's Care Plan for antibiotic therapy for prostate abscess, dated 1/8/2025, the care plan indicated Resident 115's goal was to be free from infection. The care plan interventions indicated to administer 1 gram of meropenem intravenously every eight hours, change the IV tubing every 24 hours, follow IV orders by checking the IV site for redness, pain at the insertion site, swelling, infiltration or phlebitis, adverse reaction to infusion. The interventions indicated to ensure the IV device is intact and saline flush 10 milliliters (ml, unit of volume) every eight hours before and after medication administration During an interview on 1/29/2025 at 8:14 a.m. with Registered Nurse (RN) 1, RN 1 stated when a nurse did not administer a medication to a resident, the nurse must document on the MAR the reason the medication was not administered and the nurse must document the notification to the doctor. RN 1 stated blank entries on the MAR was not acceptable because it creates confusion about the medication administration and the monitoring of the IV site. During a concurrent interview and record review on 1/29/2025 at 8:38 a.m. with RN 1, Resident 115's MAR, for the month of January 2025 was reviewed. The MAR indicated on multiple days, there were no licensed staff initials in the box for Meropenem, to demonstrate the medication was administered. The MAR indicated on multiple days, there were no licensed staff initials in the box for monitoring Resident 115's IV site, flushing of the IV site and changing the IV tubing to demonstrate IV monitoring was performed. RN 1 stated blank entries on the MAR meant Meropenem was not administered and the IV site monitoring was not performed. RN 1 stated all IV monitoring must be performed to keep it free from infection and to be alert if the IV was not working. During a concurrent interview and record review on 1/29/2025 at 8:50 a.m. with RN 1, Resident 115's Nursing progress notes, dated 1/2025, were reviewed. RN 1 stated there were no progress notes indicating why Resident 115 did not receive Meropenem or that the resident's doctor was notified. RN 1 stated she did not document when she informed Resident 115's and did not document the doctors' response. RN 1 stated she was supposed to document the doctor's new orders on the nursing progress notes. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure (P&P) titled Charting and Documentation dated 4/2008, the P&P indicated all observations, medications administered, services performed, etc., must be documented in the resident's clinical records.

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hire a qualified full-time social worker in a facility with more than 120 beds. 45009 Based on interview and record review, the facility failed to employ a social worker that met the basic qualifications of having a bachelor's degree (an undergraduate degree) in social work (profession that helps people improve their lives and overcome challenges) or in the human services field (field that provides support and assistance to individuals, families, and communities in need). This deficient practice had the potential to affect 115 residents residing in the facility by potentially not receiving the assistance and guidance they needed to attain their highest practicable well-being. Findings: During a review of the Social Services Director (SSD) bachelor's degree certificate, dated 11/2020, the bachelor's degree certificate indicated it was awarded for Applied management. During an interview on 1/29/2025 at 3:40 p.m. with the SSD, the SSD stated she had been working at the facility for 5 months. The SSD stated she had a bachelor's degree in applied administration. The SSD stated she did not have a social worker certificate. The SSD stated she had never worked as a social worker in a healthcare setting because she was not a social worker. The SSD stated the facility required her to have a bachelor's degree and 1 to 2 years' of experience in social work. The SSD stated she had experience helping people in the community with housing needs and other resources but not in a healthcare setting. During an interview on 1/31/2025 at 11:35 a.m. with the Administrator (Admin), the Admin stated he required the SSD to have a bachelor's degree in line with job function and a minimum of 1 year experience in social work. The Admin stated he was aware that SSD did not have a bachelor's degree in social work or in healthcare. The Admin stated residents did not receive the support they needed because the SSD did not encompass the knowledge a social worker had. The Admin stated it was important to employ staff with required qualifications to ensure they are able to meet resident's needs. During a review of the facility's Job description for Social Service Supervisor, dated 2023, the job description indicated the education/vocational requirement for a social worker supervisor was an accredited bachelor's in social work and two years' experience as a social worker.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38740 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment by failing to: 1. Ensure five water pitchers were not stored on top of the ice machine located in the ice machine room outside of the kitchen. 2. Ensure dirty resident water pitchers from the previous evening (identified by a blue color) were not stored on the same rack as the clean water pitchers (identified by a pink color) located in the ice machine room. 3. Ensure Resident 115 intravenous ([IV] a method of administering fluids or drugs directly into a vein using a needle or tube) dressing was changed and monitored. These deficient practices had the potential to cross contaminate ice and water pitchers and cause food borne illness in 115 out of 120 residents, staff and visitors who consume the ice or water in the facility. This deficient practice also increased the risk for Resident 115 to get an infection to the IV site and possibly delay treatment. Findings: 1. During a concurrent observation and interview with the Assistant Dietary Supervisor (ADS), in the Ice Machine Room, on 1/27/2025 at 10:15 a.m., there were five dirty water pitchers on top of the ice machine. The water pitchers were blue in color. The pitchers were wet and contained some water at the bottom of the pitcher. The top of the ice machine was wet. A sweep with a clean white paper towel on top of the ice machine produced red colored stains. There was a 3-shelf rack with water pitchers stored on top of them. The ADS stated staff should not put dirty pitchers on top of the ice machine. The ADS pointed to the rack next to the ice machine and stated, only clean pitchers were stored on the rack in the ice machine room. The ADS stated the water pitchers were color coded (blue and pink) and staff followed the schedule to know which colored pitcher to use. During a concurrent interview and review of the water pitcher schedule posted on the wall, on 1/27/2025 at 10:20 a.m., with the ADS, the ADS stated for 1/27/2025, the pink colored pitchers were the clean pitchers. The ADS stated there should not be any blue colored pitchers in the ice machine room and on the rack inside the ice machine room. 2. During a concurrent observation and interview with the Dietary Aide (DA 1) on 1/27/2025 at 10:30 a.m., in the Ice Machine Room, observed some blue and pink colored water pitchers mixed together. DA 1 stated dirty water pitchers were collected by nursing staff and should be left outside of the kitchen door to be washed. DA 1 stated the blue colored water pitchers were from the day before (1/26/2025) were dirty. DA 1 stated only pink colored water pitchers were clean and in use that day (1/27/2025). DA 1 stated there were some blue colored pitchers mixed in with pink colored pitchers in the ice machine room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056023	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Villa Care Center	12029 Avalon Blvd Los Angeles, CA 90061

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview with Certified Nursing Assistant (CNA) 5 on 1/27/2025 at 11:20 a.m., CNA 5 was observed removing a blue colored pitcher from a resident room. CNA 5 filled the water pitcher with water and ice and returned it to the resident. CNA 5 stated she forgot which color pitchers were clean. CNA 5 stated nursing staff working the 11 pm-7 am shift would bring the old water pitchers to the kitchen and grab new ones form the ice machine room before their shift ended. CNA 5 stated there should not be water pitchers on top of the ice machine because it could cross contaminate the ice machine and the clean area. During an interview with the Director of Staff Development (DSD) on 1/27/2025 at 11:30 a.m., the DSD stated staff working the 11 pm-7 am shift changed the water pitchers per the color code. The DSD stated all residents should have the pink colored water pitchers at their bed side that day (1/27/2025). The DSD stated staff were trained to take the dirty water pitchers to the kitchen to be washed and grab new ones from the ice machine. The DSD stated there was no facility policy for the process and staff were trained on this protocol upon hire. During an interview with the Infection Prevention Nurse (IPN) on 1/28/2025 at 3:30 p.m., the IPN stated the ice machine room was for clean water pitcher storage and was considered a clean area. The IPN stated there should not be any used or dirty items in the ice machine room. The IPN stated dirty water pitchers stored in the ice machine room could cross contaminate the clean pitchers and the ice. The IPN stated when residents request more water or ice, CNAs should take the water pitcher from the residents' room to the kitchen to be washed and grab a new one from the ice machine room. The IPN stated the facility did not have a policy for the use and cleaning of water pitchers. The IPN stated there was a schedule posted on the wall that determined which color water pitchers were clean. The IPN stated the water pitcher storage rack should only contain clean water pitchers. During an interview with the Dietary Supervisor (DS) on 1/29/2025 at 2:00 p.m., the DS stated kitchen staff were responsible for the daily cleaning of the ice machine external compartments and the ice scooper. The DS stated on 1/27/2025 the dirty water pitchers stored on top of the ice machine and on the clean racks were taken out of the room and washed. The DS stated the dietary aide cleaned the ice machine and the scooper daily. The DS sated the cleaning log were not marked by the DA. 45009 3. During an observation on 1/27/2025 at 10:23 a.m., in Resident 115's room, observed Resident 115 with an IV on his left upper arm. Resident 115's IV dressing was dated 1/7/2024. During a review of Resident 115's Admission Record, the admission record indicated Resident 115 was admitted to the facility on [DATE] with diagnoses including abscess (swollen area within body tissue, containing an accumulation of pus) of the prostate (a gland in the male reproductive system), and diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 115's History and Physical (H&P) dated 1/10/2025, the H&P indicated Resident 115 had the capacity to understand and make decisions. (continued on next page)

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	056023	A. Building B. Wing	01/31/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 115's Minimum Data Set (MDS, a mandated resident assessment tool), dated 1/19/2025, the MDS indicated Resident 115's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was intact. The MDS indicated Resident 115 was independent for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 115's Care Plan for antibiotic therapy for prostate abscess, dated 1/8/2025, the care plan indicated Resident 115's goal was to be free from infection. The care plan interventions indicated to monitor Resident 115's IV site dressing and ensure the site is clean, dry, and intact every shift for 30 days. During a review of Resident 115 Electronic Medical Record, unable to locate documentation indicating Resident 115's IV site was monitored. During an interview on 1/27/2025 at 10:29 a.m. with Resident 115, Resident 115 stated his IV was inserted on 1/7/2025. Resident 115 stated the nursing staff had not changed his IV dressing. Resident 115 stated he asked the night shift nurse to change the dressing and she stated she would but never did. Resident 115 stated he was concerned about the dressing because it was no longer white and that it was brown and he did not want to get an infection. During an interview on 1/29/2025 at 8:14 a.m. with Registered Nurse (RN) 1, RN 1 stated IV dressings must be changed once a week or as needed for infection control. RN 1 stated nurses must date and initial the IV dressing. RN 1 stated it was important to maintain the IV dressing in a dry, clean and intact manner to prevent IV complications. RN 1 stated Resident 115 did not have any orders for an IV dressing change. RN 1 stated Resident 115's IV dressing had not been changed since it was inserted on 1/7/2025. During a review of the facility's Policy and Procedure (P&P) titled Peripheral IV Dressing Changes, dated 2016, the P&P indicated its purpose of his procedure was to prevent catheter-related infections associated with contaminated, loosened or soiled catheter-site dressings. The P&P indicated to change the IV dressing at least every 5 to 7 days. The P&P indicated to label IV dressing with date, time, and initials.