STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056065	A. Building B. Wing	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Cruz Post Acute	1115 Capitola Road Santa Cruz, CA 95062

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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** 44583 Based on observation, interview, and record review, the facility failed to maintain respect, and dignity to three of 28 sampled residents (Residents 46, 296, and 133) when: 1.Residents 46 and 296's indwelling catheter's (a catheter which is inserted into the bladder, thru the urethra and remains in place to drain urine) urinary bags were exposed and not covered with a privacy bag; and 2.Resident 133's personal information and care guide was posted in the room visible to roommate's visitors. These failures had the potential to negatively affect resident's emotional and psychosocial well-being. Findings: 1a. During an observation on 2/24/2025 at 8:53 a.m., inside Resident 46's room, Resident 46 was resting on her bed, talking to self. A urinary bag was observed hanging under the bed, exposed, and not covered with a privacy bag. During a concurrent observation and interview with registered nurse F (RN F) on 2/25/2025 at 9:55 a.m., inside Resident 46's room, Resident 46's urinary bag was still exposed containing 400 milliliters (ml, volume of measurement) of yellow urine, and not covered. RN F confirmed above observation, and stated, I am just a part time here and I cannot babysit everybody. RN F further stated it (urinary bag) should have been covered. During a review of Resident 46's clinical record titled, Order Summary Report, order dated 12/17/2024, indicated, Indwelling urinary (Foley) catheter is in privacy bag . During a review of Resident 46's care plans titled, Bladder: At risk for complication with urinary system related to indwelling catheter, date initiated 2/8/2025, indicated in one of the interventions, Privacy cover to catheter bag as indicated to promote dignity. (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	1b. During an observation on 2/24/2025 at 9:15 a.m., inside Resident 296's room, Resident 296's bed was near the door. Resident 296 was eating breakfast in bed, and the indwelling catheter's urinary bag was hanging at the right side of bed, exposed with 200 ml of yellow urine which could be seen by passersby at the hallway. The urinary bag was not inside a privacy bag. During a concurrent observation and interview with RN F on 2/24/2025 at 9:19 a.m., inside Resident 296's room, RN F confirmed above observation, and stated the urinary bag should have been covered. During a review of Resident 296's minimum data set (MDS - a federally mandated resident assessment tool) admission assessment dated [DATE], indicated Resident 296's brief interview for mental status (BIMS, a tool used to assess cognition [knowing, learning, and understanding things]) score was 11 (0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact). During an interview with director of nursing (DON) on 2/25/2025 at 10:21 a.m., DON confirmed residents' urinary bags should be covered to maintain residents' dignity. During a review of the facility's policy and procedure titled, Dignity, date revised February 2021, indicated, Residents are treated with dignity and respect at all times .Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example: a. helping the resident to keep urinary catheter bags covered . 2. During a concurrent observation and interview with RN F on 2/24/2025 at 9:20 a.m., inside Resident 133's room, Resident 133 was eating breakfast in bed and there were two paper notes posted at the wall above Resident 133's head of bed (HOB). One note titled, Swallowing /Mealtime Precautions, indicated Resident 133's full name and the following, Diet/Texture: Mech [mechanical] SOFT; Liquids: Thin; Supervision: Checking in; Medications: Whole 1at a time; Swallow Precautions: SET Up! *open Salad dressing, etc. *assist upright posture. *In w/c [wheelchair] is best. *Mandarin speaking. Please Anticipate Needs! He will NOT express needs independently. Another note posted, indicated, Fluid Restriction 1200 ml/day AM: 600 mL; PM: 400 mL; NOC: 200 mL. Resident 133 was sharing a room with two other residents. RN F confirmed above observation. RN F stated it should have been covered. During a review of Resident 133's MDS admission and 5 day assessment dated [DATE], it indicated Resident 133 had memory problem. During an interview with director of nursing (DON) on 2/25/2025 at 10:32 a.m., DON stated residents' care instructions should have to be covered. DON confirmed they have a new dietitian, and she did not know their policy about postings inside resident's room. During a review of the facility's policy and procedure titled, Dignity, date revised February 2021, indicated, Staff protect confidential clinical information. Examples include the following .b. Signs indicating the resident's clinical status or care needs are not openly posted in the resident's room unless specifically requested by the resident or family member. Discreet posting of important clinical information for safety reasons is permissible (e.g., taped to the inside of the closet door).

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on observation, interview, and record review, the facility failed to implement their policy and procedure on self-administration of medication (resident takes medication without staff assistance) when there were no documentation found in resident's records for self-administration of medication, and medications were left at bedside for two of 28 sampled residents (Residents 113 and 44). This failure had the potential for unsafe and improper administration of medications. Findings: 1.Review of Resident 113's clinical record titled, Admission Record, dated 2/25/2025, indicated Resident 113 was admitted to the facility with diagnoses including low back pian, opioid use (a chronic disease that involves compulsive use of opioids [a class of drug used to reduce moderate to severe pain], even when it harms a person's life), and chronic pain syndrome (pain that lasts longer than three months, or past the normal healing time). Review of Resident 113's minimum data set (MDS - a federally mandated resident assessment tool) quarterly assessment dated [DATE], indicated Resident 113's brief interview for mental status (BIMS, a tool used to assess cognition [knowing, learning, and understanding things]) score was 14 (a score of 13-15 indicates patient is cognitively intact). During an observation on 2/23/2025 at 10:25 a.m., inside Resident 113's room, Resident 113 was seated at the edge of bed and a bottle of lidocaine (a medication that numbs areas of tissue) pain relief roll on was observed on top of Resident 113's bedside drawer. Resident 113 confirmed he was using the lidocaine pain relief roll on for his knee pain. During a concurrent interview with licensed vocational nurse K (LVN K) and record review on 2/24/2025 at 1:48 p.m., LVN K reviewed Resident 113's physician's order for lidocaine pain relief roll on. LVN K confirmed Resident 113 did not have an order of lidocaine pain relief roll on and an order to have it a bedside for self administration. LVN K further confirmed Resident 113 only had an order of lidocaine patch for his lower back pain. LVN K stated Resident 113 should not have the lidocaine pain relief roll on at bedside because there was no self-administration assessment of the medication completed, and there was no physician order for him to have the lidocaine pain relief roll on. 2.Review of Resident 44's clinical record titled, Admission Record, dated 2/26/2025 indicated, Resident 44 was admitted to the facility with diagnoses including spondylosis of the lumbar region (a chronic condition that occurs when the vertebrae and disks of the lower back degenerate, also known as osteoarthritis), mild cognitive impairment (a condition in which people have more memory or thinking problems than other people their age), and failure to thrive (a state of decline that is multifactorial and may be caused by chronic concurrent diseases and functional impairment). Review of Resident 44's MDS quarterly assessment dated [DATE], indicated Resident 44's BIMS score was 11, with moderate cognitive impairment. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 2/23/2025 at 10:42 a.m., inside Resident 44's room, Resident 44 was seated at the edge of bed, with bedside commode next to her bed and two bottles of wound cleansers were observed on top of her overbed table. Resident 44 confirmed she used the wound cleansers to wash her hands after she used the bedside commode. During a concurrent interview with LVN K and record review on 2/24/2025 at 1:58 p.m., LVN K reviewed Resident 44's physician orders. LVN K confirmed Resident 44 should not have wound cleansers on top of her overbed table. LVN K stated the wound cleansers should have been kept in their treatment carts. During an interview with the director of nursing (DON) on 2/25/2025 at 10:14 a.m., DON confirmed all their residents should not have medication at bedside. DON stated medications should not be left on resident's overbed table or bedside drawer. DON further stated a resident can only have medication at bedside when: they were determined safe to self-administer the medication based on the self-administration assessment, there was a physician's order, it was care planned and the medication was stored in a locked box at resident's bedside drawer. During a review of the facility's policy and procedure titled, Self-Administration of Medications, dated 2/2021, indicated, Residents have the right to self-administer medication .If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan .Self -administered medications are stored in a safe and secure place, which is not accessible by other residents . Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party .

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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** 44583 Based on observation, interview, and record review, the facility failed to ensure needs were accommodated for one of 28 sampled residents (Resident 296) when the call button (a red or white button used to call for assistance) was not within Resident 296's reach for use. This failure had the potential for a delayed response and not meeting the resident's needs timely. Findings: Review of Resident 296's clinical record titled, Admission Record, dated 2/25/2025, indicated Resident 296 was admitted to the facility with diagnoses including nondisplaced fracture (the bone cracks or breaks but retains its proper alignment) of left tibial tuberosity (a bony bump on the front of the upper part of the shin bone), repeated falls, and difficulty walking. Review of Resident 296's minimum data set (MDS - a federally mandated resident assessment tool) admission assessment dated [DATE], indicated Resident 296's brief interview for mental status (BIMS, a tool used to assess cognition [knowing, learning, and understanding things]) score was 11 (score of 8-12 indicates moderate impairment) During a concurrent observation and interview with Resident 296 on 2/24/2025 at 9:15 a.m., inside Resident 296's room, Resident 296 was eating breakfast in bed. Resident 296 complained he didn't know where his call button was located. Resident 296 tried to check both sides of his bed and still couldn't find his call button. Resident 296's call button was observed on the floor near the bed's wheels. During a concurrent observation and interview with registered nurse F (RN F) on 2/24/2025 at 9:19 a.m., inside Resident 296's room, RN F confirmed the above observation. RN F stated the call button should have been within Resident 296's reach for use. During an interview with the director of nursing (DON) on 2/25/2025 at 10:21 a.m., the DON stated call buttons or call lights should always be within resident's reach for use. During a review of the facility's policy and procedure titled, Call System, Residents, date revised 9/2022, indicated, Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member .Each resident is provided with a means to call staff directly for assistance from his/her bed .

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on interview, and record review, the facility failed to complete a comprehensive minimum data set (MDS - a federally mandated resident assessment tool) admission assessment and a required discharge assessment in a timely manner for one of 10 residents (Resident 120). This failure resulted in Resident 120's admission and discharge assessment not completed within the time requirement and had a potential to result in inappropriate care planning and intervention. Findings: A.Review of Resident 120's clinical record titled, Admission Record, dated 2/26/2025, indicated Resident 120 was admitted at the facility on 10/13/2024 with diagnoses including osteoarthritis (OA, a progressive disorder of the joints, caused by a gradual loss of cartilage) of first carpometacarpal joint (the saddle-shaped joint at the base of the thumb that connects the thumb to the wrist), left hand, chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and asthma (inflammatory disease of the airway that often causes wheezing, coughing, and shortness of breath). Further review, indicated Resident 120 was discharged on [DATE]. During a concurrent interview and record review on 2/26/2025 at 3:58 p.m., minimum data set coordinator A (MDSC A) reviewed Resident 120's admission record and MDS assessments. MDSC A confirmed Resident 120 was admitted on [DATE] and discharged to home on 1/20/2025. MDSC A stated the required timeframe to complete the MDS discharge assessment - return not anticipated should be 14 days from the discharge date . MDSC A confirmed Resident 120's MDS discharge assessment - return not anticipated was completed late on 2/11/2025 when it should have been completed on 2/3/2025. Review of Center for Medicare and Medicaid Services' Long-Term Care Facility Resident Assessment Instrument (CMS's LTCF RAI - a guide for facility staff to existing coding and transmission) Manual 3.0 Version 1.19.1, dated 10/2024, indicated, Discharge Assessment-return not anticipated - MDS Completion Date No Later Than - discharge date + 14 calendar days. B.During a concurrent interview and record review on 2/27/2025 at 8:55 a.m., MDSC A reviewed Resident 120's admission assessment combined with 5-day assessment. MDSC A stated based on the RAI manual, the MDS admission assessment should be completed on the 14th day of the resident's admission. MDSC A confirmed Resident 120's MDS admission assessment was completed late on 11/3/2024 when it should have been completed on 10/26/2024. Review of CMS's LTC RAI Manual 3.0 Version 1.19.1, dated 10/2024, indicated, Admission (Comprehensive) - MDS Completion Date No Later Than - 14th calendar day of the resident's admission (admitted + 13 calendar days).

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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** 27000 Based on interview and record review, the facility failed to ensure the comprehensive care plans were developed and implemented for 11 of 40 sampled residents (Resident 10, 19, 38, 54, 67, 72, 93, 104, 111, 121, and 287). This failure placed the residents at risk of not being provided appropriate, consistent, and individualized care. Findings: 1. A review of Resident 104's admission record indicated he was admitted to the facility with diagnoses including heart failure (condition where the heart cannot pump enough blood to meet the body's needs). A review of the physician's orders indicated an order, dated 4/12/24, for amiodarone (a anti-arrhythmic medication, to treat irregular heart rhythms) 200 milligrams (mg, unit of measurement), 1 tablet by mouth one time a day for arrhythmia. A review of Resident 104's clinical record indicated no care plan was developed and implemented for Resident 104's arrhythmia and use of amiodarone. During a concurrent interview and record review with the Director of Nursing (DON), the Infection Control Preventionist (IP), and Nurse Supervisor D (NS D) on 2/27/25 at 1:45 p.m., they reviewed Resident 104's clinical record and confirmed there was no care plan developed for arrhythmia and use of amiodarone. They acknowledged it should have been developed. 2a. A review of Resident 38's clinical record indicated the resident was admitted to the facility with diagnoses including heart failure. He had a physician's order for Digoxin [an antiarrhythmic medication] Tablet 250 MCG [micrograms, unit of measurement], Give 1 tablet by mouth one time a day for heart failure, dated 1/5/25. On 2/28/25 starting at 2:32 p.m., a review of Resident 38's clinical record with the Minimum Data Set Coordinator B (MDSC B) indicated there was no comprehensive care plan developed for the resident's heart failure or digoxin use. MDSC B stated it should have been care planned. 2b. Resident 38 also had a physician's order, dated 1/4/25, for Amiodarone . 200 MG Give 1 tablet by mouth two times a day for abnormal heart rhythm. During a concurrent interview and record review with the DON on 2/28/25, at 5:25 p.m., the DON reviewed Resident 38's list of care plans and confirmed there was no care plan in place to address Resident 38's abnormal heart rhythm and amiodarone use. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. A review of Resident 111's clinical record indicated she was admitted to the facility with diagnoses including paroxysmal atrial fibrillation (a fast, irregular heartbeat that only lasts a few hours or days). She had a physician's order for Digoxin Oral Tablet 125 MCG . Give 1 tablet by mouth one time a day for Antiarrhythmic dated 6/28/24. On 2/28/25 at 2:40 p.m. during a concurrent interview and record review with MDSC B, she reviewed Resident 111's list of care plans and stated there was no care plan developed for the use of digoxin. MDSC B stated there should have been a care plan developed. 4. A review of Resident 287's clinical record indicated the resident was admitted to the facility with diagnoses including atrial fibrillation (AF; condition where the upper chambers of the heart [atria] beat irregularly and rapidly). Resident 287 had physician's order for Digoxin Tablet 125 MCG Give 1 tablet by mouth one time a day for heart failure, dated 2/14/25. On 2/28/25 at 2:42 p.m., during a concurrent interview and record review with MDSC B, she reviewed Resident 287's list of care plans and stated she could not find any care plan for the resident's heart failure or digoxin use. She confirmed there should have been a care plan developed. 5. A review of Resident 10's clinical record indicated was admitted to the facility with diagnoses including heart failure. A review of the physician's order, dated 4/24/21 indicated, Digoxin Tablet 125 MCG Give 1 tablet by mouth one time a day for heart failure since 4/24/21. On 2/28/25 at 2:44 p.m., during a concurrent interview and record review with MDSC B, she reviewed the resident's list of care plans and stated she could not find any care plan for the use of digoxin. She acknowledged there should be a care plan for the resident's heart failure and digoxin use. 6. A review of Resident 54's clinical record indicated the resident was admitted with diagnoses including unspecified AF. She had a physician's order for digoxin tablet 125 mcg, 1 tablet by mouth one time a day for AF, dated 9/6/2023. On 2/28/25 at 3:40 p.m., during a concurrent interview and record review with MDSC B, she reviewed Resident 54's list of care plans and stated she could not find a care plan for AF or digoxin use. She confirmed there should have been a care plan developed. 7a. A review of Resident 121's clinical record indicated he was admitted to the facility with diagnoses including paroxysmal atrial fibrillation (a fast, irregular heartbeat that only lasts a few hours or days), and cardiomyopathy (a disease that affects the heart muscle, making it difficult for the heart to pump blood). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the physician's orders indicated an order for digoxin 125 mcg 1 tablet one time a day for AF, dated 10/18/24. On 2/28/25 at 3:57 p.m., during a concurrent interview and record review with MDSC B, she reviewed Resident 121's list of care plans, and stated there was no care plan for Resident 121's AF or digoxin use. 44583 7b. Resident 121 also had another physician's order, dated 12/20/24, for Amiodarone . 100 MG Give 1 tablet by mouth one time a day for CHF [chronic heart failure, a condition where the heart can't pump enough blood to meet the body's needs]. During a concurrent interview with the Assistant Director of Staff Development (ADSD) and record review on 2/28/2025 at 3:35 p.m., the ADSD reviewed Resident 121's physician order and list of care plans. The ADSD confirmed there was no care plan developed for Resident 121's amiodarone use. 8. Review of Resident 67's clinical record titled, Admission Record, dated 2/28/25, indicated Resident 67 was admitted to the facility with diagnoses including unspecified diastolic heart failure (a condition in which the heart's main pumping chamber becomes stiff and unable to fill with enough blood and reducing the amount of blood pumped out to the body), hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, and unspecified atrial fibrillation. Review of Resident 67's physician order, dated 11/17/2020, indicated, Amiodarone . 200 MG Give 1 tablet by mouth one time a day for Arrythmia. During a concurrent interview with minimum data set coordinator B (MDSC B) and record review on 2/28/25 at 4:21 p.m., MDSC B reviewed Resident 67's physician order and list of care plans, and confirmed there was no care plan developed for Resident 67's amiodarone use. 9. Review of Resident 72's clinical record titled, Admission Record, dated 2/28/25, indicated Resident 72 was admitted at the facility with diagnoses including nonrheumatic mitral valve prolapse (a heart condition that occurs when the mitral valve [a heart valve between the left upper chamber and left lower chamber of the heart] flaps bulge into the left atrium of the heart), left bundle-branch block (occurs when something blocks or disrupts the electrical impulse that causes the heart to beat), atherosclerotic heart disease of native coronary artery (a buildup of plaque in the coronary arteries that supply blood to the heart), bradycardia (a condition where the heart rate is abnormally slow, typically below 60 bpm), presence of cardiac pacemaker (a small device that's implanted in the chest to regulate the heart's rhythm and rate), presence of aortocoronary bypass graft (CABG - a surgical procedure that improves blood flow to the heart) and presence of coronary angioplasty implant and graft (a minimally invasive procedure that uses a balloon to widen a blocked artery, and a stent to keep it open). Review of Resident 72's physician order, dated 2/11/25, indicated, Amiodarone .100 MG Give 1 tablet by mouth one time a day for bradycardia. (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 with MDSC B and record review on 2/28/25 at 4:26 p.m., MDSC B reviewed Resident 72's physician order and list of care plans, and confirmed there was no care plan developed for Resident 72's amiodarone used. MDSC B stated there should have been a care plan developed for Resident 72's amiodarone used which indicated about amiodarone's black box warning monitoring and the parameters of blood pressure (BP) and heart rate (HR) prior to administration of the medication. 46001 10. A Review of Resident 19' clinical record indicated Resident 19 was admitted to the facility on [DATE] with diagnoses including heart failure and unspecified atrial fibrillation. A review of Resident 19's physician order, dated 8/19/24, indicated for amiodarone 100 mg give 1 tablet by mouth one time a day for arrhythmia. Hold for SBP less than 110 or heart rate (HR) less than 60. The start date was 8/19/24. During a concurrent interview and record review with the DON on 2/28/25, at 5:23 p.m., the DON reviewed Resident 19's physician order and MARs (medication administration record) for December 2024, January, and February 2025. The DON confirmed there was no care plan in place to address Resident 19's abnormal heart rhythm and amiodarone use. 11. A Review of Resident 93's clinical record indicated Resident 93 was admitted to the facility on [DATE] with diagnoses including essential hypertension, heart failure, and a personal history of sudden cardiac arrest. A review of Resident 93's physician order, dated 2/3/25, indicated for amiodarone 200 mg, Give 1 tablet by mouth two times a day for abnormal heart rhythm. The start date was 2/3/25. During a concurrent interview and record review with DON on 2/28/25, at 5:27 p.m., the DON reviewed Resident 93's list of care plans and confirmed there was no care plan in place to address Resident 93's abnormal heart rhythm and amiodarone use. A review of the facility's undated policy and procedures titled Care Plans, Comprehensive Person-Centered indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.

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Santa Cruz Post Acute	1115 Capitola Road Santa Cruz, CA 95062

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44185 Based on observation, interview and record review, the facility failed to provide care in accordance with professional standards of practice for three of 40 sampled residents, (Residents 34, 124 and 5), when: 1. Resident 34, had no documentation that her weights were being monitored for the last 3 months; 2. Resident 124's STAT (is derived from the Latin word 'Statim, which translates to immediately, and it denotes that order should be prioritized first since it is required promptly) order for x-ray (a type of radiation that produces images of the inside of the body to diagnose and treat some conditions like bone injuries, tumors, and infections) to left knee was not carried out in a timely manner; and 3. Resident 5, the licensed nurse did not follow physician's order regardinging the prescribed frequency of water flushes during gastrostomy tube (GT, a tube inserved via the abdomen for feeding/medication administration) feeding. These failures had the potential for the residents, not to attain or maintain their highest practicable physical, mental and psychosocial well-being. Findings: 1.During an observation on 2/23/25 at 12:37 p.m., Resident 34 was sitting on her wheelchair in the hallway. Resident 34 was confused and could not respond to questions. Review of Resident 34's admission record (a document created during the resident's admission to the healthcare facility containing their personal details and medical history) indicated, Resident 34 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (blood flow to the brain is interrupted, causing brain tissue to die) due to unspecified occlusion (blockage or closing of an opening) or stenosis (narrowing of a tubular structure in the body) of unspecified carotid artery (large blood vessel located on either side of the neck), vascular dementia (brain damage caused by multiple strokes causing memory loss), unspecified severity without behavioral disturbance (range of conditions that involve disruptive or extreme behaviors), psychotic disturbance (loss of contact with reality), mood disturbance (mental health condition that affects primarily the emotional state) and anxiety (excessive worrying) and unspecified recurrent (happens repeatedly) major depressive disorder (persistent feelings of sadness or hopelessness). Review of Resident 34's order summary report (concise document that compiles all the orders placed for a resident) indicated, Resident 34 had an order for monthly weight check, one time a day every 1 month starting on the first for 1 day for monthly weight check every month per physician's order until discontinued. This was ordered on 3/22/24 and was started on 4/1/24. Review of Resident 34's weight records indicated, Resident 34 did not have record of her weights for 3 months. There were no weight records of Resident 34 for December 2024, January 2025 and February 2025. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent review of Resident 34's clinical records and interview with the assistant director of staff development (ADSD) on 2/28/25 at 1:01 p.m., the ADSD verified that there was no record and documentation that Resident 34 was weighed on December 2024, January 2025 and February 2025. The ADSD acknowledged that Resident 34 was last weighed on 11/4/24 and the order of Resident 34 was to weigh her every first day of the month which was not followed. During another interview with the ADSD on 2/28/25 at 1:55 p.m., the ADSD further acknowledged that they could not find any weight record of Resident 34 for December 2024, January 2025 and February 2025. The ADSD then stated that they will weigh Resident 34 right away. During an interview with the director of nursing (DON) on 2/28/25 at 5:35 p.m., the DON verified the finding that Resident 34 did not have weight records for December 2024, January 2025 and February 2025 and the order was not followed. She then stated that she will follow up on it. Review of the facility's policy titled, Medication and Treatment Orders, revised July 2016, indicated, Orders for medications and treatments will be consistent with principles of safe and effective order writing Review of the facility's policy and procedure titled, Weight Assessment and Intervention, revised March 2022, indicated, Resident weights are monitored for undesirable or unintended weight loss or gain Weights are recorded in each unit's weight record chart and in the individual's medical record 44583 2.Review of Resident 124's Admission Record, dated 2/25/2025, indicated Resident 124 was admitted to the facility with diagnoses including rhabdomyolysis (a condition where muscle tissue breaks down, releasing harmful substances into the bloodstream), morbid (severe) obesity (abnormal or excessive fat accumulation that presents a risk to health) due to excess calories, and difficulty walking. Review of Resident 124's admission minimum data set (MDS - a federally mandated resident assessment tool) assessment dated [DATE], indicated Resident 124's brief interview for mental status (BIMS, a tool used to assess cognition [knowing, learning, and understanding things]) score was 14 (a score of 13-15 indicates patient is cognitively intact). During a concurrent observation and interview with Resident 124 on 2/23/2025 at 11:05 a.m., inside Resident 124's room, Resident 124 was observed seated at the edge of his bed. Resident 124 stated he was still getting physical therapy and complained of left knee pain. Resident 124's left knee was observed swollen down to his left lower leg which was bigger compared to his right leg. Resident 124 stated he was scheduled to discharge out of the facility on Friday, 2/28/2025. During another concurrent observation and interview with Resident 124 on 2/25/2025 at 4:02 p.m., at the facility's common activity area, Resident 124 was observed seated and was watching television (TV). Resident 124 stated he walked from his room to the common activity area with the use of a rollator (a wheeled walker with a seat that helps people with balance issues or limited mobility walk longer distances). Resident 124's left leg was observed bigger than it was observed on 2/23/2025. Resident 124 stated, they will do an x-ray to my left knee. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 124's physician order dated 2/25/2025, indicated, STAT X-ray to Left Knee r/t [related to] c/o [complain of] Pain one time only until 2/25/2025 23:59 [military time for 11:59 p.m.]. The order was entered on 2/25/2025 at 2:53 p.m. During an interview with minimum data set coordinator B (MDSC B) on 2/26/2025 at 8:51 a.m., MDSC B confirmed the nurse practitioner have seen Resident 124 on 2/25/2025 and have ordered a STAT x-ray to his left knee. MDSC B stated a STAT order should have been done within 4-6 hours since it was ordered. During a concurrent interview with licensed vocational nurse L (LVN L) and record review on 2/26/2025 at 9:54 a.m., LVN L reviewed Resident 124's radiology examination order form and confirmed the STAT x-ray of left knee order on 2/25/2025 was not completed yet. During a concurrent interview with DON and record review on 2/26/2025 at 10:13 a.m., DON reviewed Resident 124's nurse's documentations and confirmed the x-ray to left knee was not completed yet. DON further confirmed there was no documentation that nurses followed up the STAT x-ray to the diagnostic laboratory on 2/25/2025. DON stated a STAT order should have been done within 4 hours from the time it was ordered. During a review of the facility's policy and procedure titled, Request for Diagnostic Services, date revised 4/2007, indicated, Orders for diagnostic services will be promptly carried out as instructed by the physician's order. Emergency requests must be labeled stat (generally within 4 hours if possible) to assure that prompt action is taken. 46001 3. A review of Resident 5's clinical record indicated he was admitted to the facility on [DATE] with diagnoses including dysphagia (Difficulty swallowing foods or liquids), oropharyngeal phase, unspecified severe protein-calorie malnutrition, gastrointestinal complications, and other artificial openings of gastrointestinal tract status. A review of Resident 5's clinical record indicated a physician's order, dated 6/7/2024, for enteral feeding every shift: Jevity 1.2 at 65 mL(milliliter, a unit of measurement) per hour for 22 hours (off from 8 a.m. to 10 p.m.), with a flush of 130 mL of free water every 6 hours. During an observation in Resident 5's room on 2/23/2025 at 1:21 p.m., Resident 5 was lying in bed with the GT feeding pump running. The feeding pump was set to flush 130 mL of water every four hours. During a concurrent observation and interview in Resident 5's room with the Director of Staff Development (DSD) on 2/26/2025 at 10:37 a.m., Resident 5 was lying in bed with the GT feeding pump running. The feeding pump was set to flush 130 mL of water every four hours. The DSD confirmed that the water flush setup was 130 mL every four hours. During a concurrent interview and record review with the Director of Staff Development (DSD) on 2/26/2025 at 10:58 a.m., the DSD reviewed Resident 5's physician's order and confirmed that the water flush should have been 130 mL every 6 hours. The DSD stated that nurses should have followed the physician's enteral feeding order. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policies and procedures, titled Enteral Feedings, indicated .preventing errors in administration, 1. Check the enteral nutrition label against the order before administration. Check the following information: a. Resident name, ID, and room number; b. Type of formula; c. Date and time formula was prepared. d. Route of delivery; e. Access site; f. Method (pump, gravity, syringe); and g. Rate of administration (ml/hour).2. on the formula label, document initials, date and time the formula was hung, and that the label was checked against the order .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 44583 Based on observation, interview, and record review, the facility failed to provide appropriate care and services for indwelling catheter (a catheter which is inserted into the bladder [a sac-shaped muscular organ that stores the urine secreted by the kidneys],via the urethra [the tube through which urine leaves the body] and remains in place to drain urine) for one of three residents (Resident 46) with indwelling catheters when there was no documented indwelling catheter care for Resident 46 in some days and shifts in December 2024, January 2025 and February 2025. This failure had the potential for the resident to develop catheter associated urinary tract infection (CAUTI, an infection caused by a bacteria [germs] that get into the bladder or kidneys [a pair of organs that are on either side of the spine, just below the rib cage of a person's back] related to catheter use). Findings: Review of Resident 46's clinical record titled, Admission Record, dated 2/25/2025, indicated Resident 46 was admitted to the facility with diagnoses including wedge compression fracture (a type spinal fracture that occurs when the front of a vertebra collapses, creating a wedge shape) of third lumbar vertebra (L3 is a bone in the middle of the lower back that helps support the upper body's weight), dementia (a progressive state of decline in mental abilities), infection and inflammatory reaction due to indwelling urethral catheter and encounter for palliative care (specialized medical care that focuses on providing relief from pain and other symptoms of a serious illness). Review of Resident 46's order summary report, the order dated 12/17/2024, indicated, Indwelling Urinary (Foley) Catheter Care: cleanse with soap and water every shift [days, evening and night shifts]. During an observation on 02/24/2025 at 8:53 a.m., inside Resident 46's room, Resident 46 was observed alert, but talking to self, with indwelling catheter connected to a urinary bag. Review of Resident 46's 12/2024 treatment administration record (TAR), indicated licensed nurses had no documentation of Resident 46's catheter care was provided in the following days and shifts:12/24 - day, and night shifts; 12/25 - day shift; 12/29 - night shift; 12/30 - evening, and night shifts; and 12/31 - evening shift. Review of Resident 46's 01/2025 TAR, indicated licensed nurses had no documentation of Resident 46's catheter care was provided in the following days and shifts: 01/01 - day, and evening shifts; 01/02 - day, and night shifts; 01/03 - night shift; 01/04 - evening, and night shifts; 01/06 - day shift; 01/08 - evening shift; 01/09 - evening, and night shifts; 01/10 - evening, and night shift; 01/11 - day, and night shift; 01/12 - night shift; 01/14 - day shift; 01/15 - day, and evening shifts; 01/16 - evening shift; 01/17 - day shift; 01/18 - evening shift; 01/19 - evening shift; 01/20 - evening shift; 01/22 - evening shift; 01/23 - night shift; 01/24 - evening, and night shifts; 01/25 - evening shift; 01/26 - day, and evening shifts; 01/27 - evening shift; 01/28 - evening, and night shifts; 01/29 - day shift; 01/30 - night shift; and 01/31 - evening, and night shifts. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 46's 02/2025 TAR, indicated licensed nurses had no documentation of Resident 46's catheter care was provided in the following days and shifts: 02/01 - evening, and night shifts; 02/02 - evening, and night shifts; 02/04 - evening, and night shifts; 02/05 - evening, and night shifts; 02/06 - day, and evening shifts; 02/07 - evening, and night shifts; 02/08 - evening, and night shifts; 02/09 - evening, and night shift; 02/10 - evening shift; 02/11 - evening shift; 02/12 - evening shift; 02/13 - evening, and night shifts; 02/14 - evening shift; 02/15 - evening shift; 02/16 - evening, and night shifts; 02/17 - day shift; 02/18 - evening shift; 02/19 - day, and evening shifts; 02/20 - evening shift; 02/21 - day shift; 02/23 - day, and evening shifts; 02/24 - evening shift; and 02/25 - evening shifts. During a concurrent interview with minimum data set coordinator A (MDSC A) and record review on 02/26/2025 at 1:19 p.m., MDSC A reviewed Resident 46's admission records, order summary report and TARs for 12/2024, 01/2025, and 02/2025. MDSC A confirmed Resident 46 had indwelling catheter and had history of UTI. MDSC A further confirmed above missed documentations of Resident 46's indwelling catheter care. MDSC A stated if indwelling catheter care was not documented in the TAR, it was not done. During a concurrent interview with director of nursing (DON) and record review on 2/28/2025 at 9:45 a.m., DON reviewed Resident 46's TARs for 12/2024, 01/2025, and 02/2025 and confirmed above missed documentations of Resident 46's indwelling catheter care. DON stated nurses did not sign their names in some days and shifts in 12/2024, 01/2025, and 02/2025 for Resident 46's indwelling catheter care and confirmed if it was not signed and documented, the indwelling catheter care was not done. Review of Centers for Disease Control and Prevention's (CDC) Summary of Recommendations from the Guideline for Prevention of Catheter-Associated Urinary Tract Infections (2009) dated 3/25/2024, indicated, Proper Techniques for Urinary Catheter Maintenance .Use Standard Precautions, including the use of gloves and gown as appropriate, during manipulation of the catheter or collecting system .Routine hygiene (e.g. cleansing of the meatal surface .) is appropriate .System of documentation: Ensuring that documentation is accessible in the patient record and recorded in a standard format for data collection and quality improvement purposes is suggested .

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44185 Based on observation, interview, and record review, the facility failed to ensure the proper use of side or bed rails (adjustable rigid bars attached to the side of a bed) for 29 (Residents 21, 80, 302, 15, 40, 11, 68, 94, 23, 85, 106, 77, 27, 30, 12, 74, 4, 287, 29, 66, 91, 13, 299, 103, 75, 59, 53, 114, and 45) of 63 residents who used bed or side rails when: 1. There was no documentation of informed consents (a form in which residents are given important information, including possible risks and benefits, about a medical procedure or treatment) were obtained prior to bed/side rail use for four of 63 residents (Residents 91, 114, 45, and 59); 2. The Bed Rail Observation/Assessment was not updated in a timely manner for three of 63 residents (Residents 287, 29 and 53); 3. There were 18 of 63 residents (Residents 302,15, 40, 11, 94, 77, 27, 30, 12, 74, 287, 66, 91, 13, 103, 75, 59 and 53) who used bed rails without care plans; and 4. There was no physician orders obtained prior to the use of bed rails for 21 of 63 residents (Residents 21, 80, 302, 15, 40, 68, 94, 23, 85, 106, 77, 27, 30, 12, 74, 4, 287, 66, 13, 299, and 53). These failures had the potential to place the residents at risk of entrapment and serious injury. Findings: 1a During an observation on 2/24/2025 at 9:00 a.m., inside Resident 91's room, Resident 91 was not in her room. Resident 91's bed was observed with two upper bed rails installed and in upright position. During a concurrent observation and interview with minimum data set coordinator A (MDSC A) on 2/27/2025 at 8:42 a.m., inside Resident 91's room, Resident 91 complained that a staff removed her bed rails in the morning and stated she needed the bed rails. MDSC A confirmed Resident 91's bed rails were removed in the morning because they need to get a consent from the conservator. MDSC A further confirmed Resident 91 had been using the bed rails, but they couldn't find the consent. MDSC A stated a consent for bed rail use should have been obtained first prior to installation of bed rail and resident's use. During a concurrent interview with the regional director of clinical services (RDCS) and record review on 2/27/2025 at 10:49 a.m., the RDCS looked for Resident 91's bed rail consent for use and confirmed there was no consent found in Resident 91's medical records. The RDCS confirmed there was no documentation when the possible risks and benefits for bed rail use was explained to Resident 91's conservator prior to bed rail use. 1b. A review of Resident 114's admission record indicated Resident 114 was admitted to the facility on [DATE]. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 2/25/2025 at 1:32 p.m., inside Resident 114's room. Resident 114's bed had two upper bed rails installed and both in upright position. During a concurrent interview and record review with the RDCS on 3/3/2025 at 10:59 a.m., the RDCS reviewed Resident 114's bed rail consent and confirmed there was no signed consent found in Resident 114's medical records. The RDCS stated the consent should have been obtained prior to using the bedside rails. 1c. A review of Resident 45's admission record indicated Resident 45 was admitted to the facility on [DATE]. During an observation on 2/25/2025 with Certified Nursing Assistant O (CNA O) at 1:46 p.m., inside Resident 45's room. CNA O confirmed that Resident 45's bed had two upper bed rails installed and both in upright position. During a concurrent interview and record review with the RDCS on 3/3/2025 at 11:00 a.m., the RDCS reviewed Resident 45's bed rail consent and confirmed there was no signed consent found in Resident 45's medical records. The RDCS stated the consent should have been obtained prior to using the bedside rails. 1d. A review of Resident 59's admission record indicated Resident 59 was admitted to the facility on [DATE]. During an observation on 2/25/2025 with CNA O at 1:48 p.m., inside Resident 59's room. CNA O confirmed that Resident 59's bed had two upper bed rails installed and both in upright position. During a concurrent interview and record review with the RDCS on 3/3/2025 at 11:02 a.m., RDCS reviewed Resident 59's bed rail consent and confirmed there was no signed consent found in Resident 59's medical records.The RDCS stated the consent should have been obtained prior to using the bedside rails. 2a. During an observation on 2/23/2025 at 10:09 a.m., inside Resident 287's room, Resident 287 was in bed and observed to have two upper bed rails installed to her bed and in upright position. During a concurrent observation and interview with MDSC A on 2/27/2025 at 8:35 a.m., inside Resident 287, Resident 287 was observed in bed with two upper bed rails installed in bed and in upright position. MDSC A confirmed above observation and stated Resident 287 used the bed rails for repositioning. During a concurrent interview with the RDCS and record review on 2/27/2025 at 10:06 a.m., RDCS reviewed Resident 287's bed rail assessment/evaluation and confirmed it was last completed on 5/30/2023. The RDCS confirmed there was no latest bed rail assessment completed and stated it should have been updated quarterly. 2b. During an observation on 2/24/2025 at 8:57 a.m., inside Resident 29's room, Resident 29 was in bed, eating breakfast and observed two upper bed rails have been installed to her bed and in upright position. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview with MDSC A on 2/27/2025 at 8:40 a.m., inside Resident 29's room, Resident 29 was in bed, with two upper bed rails installed and in upright position. MDSC A confirmed above observation. MDSC A stated nurses should do a bed rail evaluation assessment upon resident's admission and should be updated quarterly, and when there was a significant change in resident's status. During a concurrent interview with the RDCS and record review on 2/27/2025 at 10:38 a.m., the RDCS reviewed Resident 29's bed rail assessment dated [DATE] and confirmed there was no other bed rail assessment completed for Resident 29. The RDCS stated there should have been an updated bed rail assessment for Resident 29. 2c. A review of Resident 53's admission record indicated Resident 53 was admitted to the facility on [DATE]. During an observation with CNA O on 2/25/2025 at 1:50 p.m., inside Resident 53's room. CNA O confirmed that Resident 53's had two upper bed rails installed and both in upright position. During a concurrent interview and record review with the RDCS on 3/3/2025 at 11:04 a.m., the RDCS reviewed Resident 53's bed rail assessment/evaluation and confirmed there was no bed rail assessment completed until 2/26/2025. The RDCS stated it should have been completed prior to using the bedside rails. 3a. During the observation of Resident 302 on 2/23/25 at 11:30 a.m., Resident 302 had his bilateral half siderails up. Review of Resident 302's admission record indicated, Resident 302 was originally admitted to the facility on [DATE]. Review of Resident 302's care plans indicated, Resident 302's siderail care plan was just created on 2/27/25. The facility already observed and assessed Resident 302 for his siderails on 10/30/24. Resident 302 did not have a siderail care plan when he was using the side rails already. 3b. During the observation of Resident 15 on 2/23/25 at 11:32 a.m., Resident 15 had his bilateral half siderails up. Review of Resident 15's admission record indicated, Resident 15 was admitted to the facility on [DATE]. Review of Resident 15's care plans indicated, Resident 15's siderail care plan was just created on 2/26/25. Resident 15 did not have a siderail care plan when it was observed on 2/23/25. 3c. During the observation of Resident 40 on 2/24/25 at 9:50 a.m., Resident 40 had his bilateral half siderails up. Review of Resident 40's admission record indicated, Resident 40 was admitted to the facility on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056065	A. Building B. Wing	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Cruz Post Acute	1115 Capitola Road Santa Cruz, CA 95062

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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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 40's care plans indicated, Resident 40's siderail care plan was just created on 2/26/25. Resident 40 did not have a siderail care plan when it was observed on 2/24/25. 3d. During the observation of Resident 11 on 2/24/25 at 9:50 a.m., Resident 11 had his bilateral half siderails up. Review of Resident 11's admission record indicated, Resident 11 was readmitted to the facility on [DATE]. Review of Resident 11's care plans indicated, Resident 11's siderail care plan was just created on 2/26/25. Resident 11 did not have a siderail care plan when it was initially ordered on 11/22/23. 3e. During the observation of Resident 94 on 2/24/25 at 3:50 p.m., Resident 94 had his bilateral half siderails up. Review of Resident 94's admission record indicated, Resident 94 was readmitted to the facility on [DATE]. Review of Resident 94's care plans indicated, Resident 94's siderail care plan was just created on 2/26/25. Resident 94 did not have a siderail care plan when it was observed on 2/24/25. 3f. During the observation of Resident 77 on 2/23/25 at 12:30 p.m., Resident 77 had his bilateral siderails up. Review of Resident 77's admission record indicated, Resident 77 was readmitted to the facility on [DATE]. Review of Resident 77's care plans indicated, Resident 77's siderail care plan was just created on 2/26/25. The facility already observed and assessed Resident 77 for his bilateral siderails on 5/28/24. Resident 77 did not have a siderail care plan when he was using the siderails already. 3g. During the observation of Resident 27 on 2/23/25 at 12:35 p.m., Resident 27 had his bilateral siderails up. Review of Resident 27's admission record indicated, Resident 27 was readmitted to the facility on [DATE]. Review of Resident 27's care plans indicated, Resident 27's siderail care plan was just created on 2/26/25. The facility already observed and assessed Resident 27 for his bilateral siderails on 7/9/24. Resident 27 did not have a siderail care plan when he was using the siderails already. 3h. During the observation of Resident 30 on 2/23/25 at 12:35 p.m., Resident 30 had his bilateral siderails up. Review of Resident 30's admission record indicated, Resident 30 was admitted to the facility on [DATE]. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 30's care plans indicated, Resident 30's siderail care plan was just created on 2/26/25. The facility already observed and assessed Resident 30 for his siderails on 4/23/24. Resident 30 did not have a siderail care plan when he was using the siderails already. 3i. During the observation of Resident 12 on 2/24/25 at 3:31 p.m., Resident 12 had her left siderail up. Review of Resident 12's admission record indicated, Resident 12 was admitted to the facility on [DATE]. Review of Resident 12's care plans indicated, Resident 12's siderail care plan was just created on 2/26/25. The facility already observed and assessed Resident 12 for her siderail on 2/13/15. Resident 12 did not have a siderail care plan when she was using the siderail already. 3j. During the observation of Resident 74 on 2/23/25 at 12:40 p.m., Resident 74 had her bilateral siderails up. Review of Resident 74's admission record indicated, Resident 74 was admitted to the facility on [DATE]. Review of Resident 74's care plans indicated, Resident 74's siderail care plan was just created on 2/26/25. The facility already observed and assessed Resident 74 for her bilateral siderails on 4/11/24. Resident 74 did not have a siderail care plan when she was using the siderails already. During the concurrent record review of the clinical records of Residents 302,15, 40, 11, 94, 77, 27, 30, 12 and 74, and interview with the RDCS, on 2/28/25 at 10:37 a.m., the RDCS verified that Residents 302,15, 40, 11, 94, 77, 27, 30, 12 and 74 did not have side rail care plans when their side rails were initiated and already used by the residents. Their side rail care plans were just recently created. During the interview with the director of nursing (DON), on 2/28/25 at 5:35 p.m., the DON acknowledged the above findings and would follow up on them. 3k. During a concurrent interview with RDCS and record review on 2/27/2025 at 10:06 a.m., the RDCS reviewed Resident 287's list of care plans and confirmed there was no care plan developed for Resident 287 prior to bed rail use. 3l. During an observation on 2/24/2025 at 9:00 a.m., inside room [ROOM NUMBER]'s room, Resident 66 was in bed, just had breakfast and observed two upper bed rails were installed in the bed and in upright position. During a concurrent observation and interview with MDSC A on 2/27/2025 at 8:41 a.m., inside Resident 66's room, Resident 66 was in bed with two upper bed rails installed and in upright position. MDSC A confirmed above observation. During a concurrent interview with the RDCS and record review on 2/27/2025 at 10:45 a.m., the RDCS reviewed Resident 66's list of care plans and confirmed there was no care plan developed for Resident 66 prior to bed rail use. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3m. During a concurrent interview with the RDCS and record review on 2/27/2025 at 10:49 a.m., the RDCS reviewed Resident 91's list of care plans and confirmed there was no care plan developed for Resident 91 prior to bed rail use. 3n. During an observation on 2/24/2025 at 9:31 a.m., inside Resident 13's room, Resident 13 was in bed watching TV, and observed two upper bed rails were installed in her bed and in upright position. During a concurrent observation and interview with MDSC A on 2/27/2025 8:44 a.m., inside Resident 13's room, Resident 13 was in bed with two upper bed rails installed and in upright position. MDSC A confirmed above observation. During a concurrent interview with the RDCS and record review on 2/27/2025 at 10:55 a.m., the RDCS reviewed Resident 13's list of care plans and confirmed there was no care plan developed for Resident 13 prior to bed rail use. The RDCS stated care plan for bed rail use should have been developed prior to installation and use of bed rails. 3o. A review of Resident 103's admission record indicated Resident 103 was admitted to the facility on [DATE]. During an observation on 2/25/2025 at 1:34 p.m., inside Resident 103's room. Resident 103's bed was observed with two upper bed rails installed and in upright position. During a concurrent interview and record review with the RDCS on 3/3/2025 at 11:06 a.m., RDCS reviewed Resident 103's care plan and confirmed there was no care plan to address the bedside rails use until 2/26/2025. The RDCS stated Resident 103 should have a siderail care plan when it was initiated. 3p. A review of Resident 75's admission record indicated Resident 75 was admitted to the facility on [DATE]. During an observation on 2/25/2025 with CNA O at 1:52 p.m., inside Resident 75's room. CNA O confirmed that Resident 75's bed was observed with two upper bed rails installed and in upright position. During a concurrent interview and record review with the RDCS on 3/3/2025 at 11:04 a.m., the RDCS reviewed Resident 75's care plan and confirmed there was no care plan to address the bedside rails use until 2/26/2025. The RDCS stated Resident 75 should have a siderail care plan when it was initiated. 3q. A review of Resident 59's admission record indicated Resident 59 was admitted to the facility on [DATE]. During an observation on 2/25/2025 with CNA O at 1:48 p.m., inside Resident 59's room. CNA O confirmed that Resident 59's bed had two upper bed rails installed and both in upright position. During a concurrent interview and record review with the RDCS on 3/3/2025 at 11:04 a.m., the RDCS reviewed Resident 59's care plan and confirmed there was no care plan to address the bedside rails use until 2/27/2025. The RDCS stated Resident 59 should have a siderail care plan when it was initiated. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3r. A review of Resident 53's admission record indicated Resident 53 was admitted to the facility on [DATE]. During an observation on 2/25/2025 with CNA O at 1:50 p.m., inside Resident 53's room. CNA O confirmed that Resident 53's bed had two upper bed rails installed and both in upright position. During a concurrent interview and record review with the RDCS on 3/3/2025 at 11:04 a.m., the RDCS reviewed Resident 53's care plan and confirmed there was no care plan to address the bedside rails use until 2/26/2025. The RDCS stated Resident 53 should have a siderail care plan when it was initiated. 4a. During the observation of Resident 21 on 2/23/25 at 11:27 a.m., Resident 21 had her bilateral half siderails up. Review of Resident 21's admission record (document created when a resident is admitted to a healthcare facility, containing the vital information about the resident), indicated, Resident 21 was initially admitted to the facility on [DATE]. Review of Resident 21's physician orders indicated, Resident 21's siderail order was just created on 2/26/25. Resident 21 did not have a siderail order when it was initiated and used. 4b. During the observation of Resident 80 on 2/23/25 at 11:27 a.m., Resident 80 had her bilateral siderails up. Review of Resident 80's admission record indicated, Resident 80 was admitted to the facility on [DATE]. Review of Resident 80's physician orders indicated, Resident 80's siderail order was just created on 2/26/25. Resident 80 did not have a siderail order when it was initiated and used. 4c. During the observation of Resident 302 on 2/23/25 at 11:30 a.m., Resident 302 had his bilateral half siderails up. Review of Resident 302's admission record indicated, Resident 302 was originally admitted to the facility on [DATE]. Review of Resident 302's physician orders indicated, Resident 302's siderail order was just created on 2/27/25. Resident 302 did not have a siderail order when it was initiated and used. 4d. During the observation of Resident 15 on 2/23/25 at 11:32 a.m., Resident 15 had his bilateral half siderails up. Review of Resident 15's admission record indicated, Resident 15 was admitted to the facility on [DATE]. Review of Resident 15's physician orders indicated, Resident 15's siderail order was just created on 2/26/25. Resident 15 did not have a siderail order when it was initiated and used. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4e. During the observation of Resident 40 on 2/24/25 at 9:50 a.m., Resident 40 had his bilateral half siderails up. Review of Resident 40's admission record indicated, Resident 40 was admitted to the facility on [DATE]. Review of Resident 40's physician orders indicated, Resident 40's siderail order was just created on 2/26/25. Resident 40 did not have a siderail order when it was initiated and used. 4f. During the observation of Resident 68 on 2/24/25 at 10:00 a.m., Resident 68 had her bilateral siderails up. Review of Resident 68's admission record indicated, Resident 68 was readmitted to the facility on [DATE]. Review of Resident 68's physician orders indicated, Resident 68's siderail order was just created on 2/26/25. Resident 68 did not have a siderail order when it was initiated and used. 4g. During the observation of Resident 94 on 2/24/25 at 3:50 p.m., Resident 94 had his bilateral half siderails up. Review of Resident 94's admission record indicated, Resident 94 was readmitted to the facility on [DATE]. Review of Resident 94's physician orders indicated, Resident 94's siderail order was just created on 2/26/25. Resident 94 did not have a siderail order when it was initiated and used. 4h. During the observation of Resident 23 on 2/24/25 at 3:35 p.m., Resident 23 had his bilateral siderails up. Review of Resident 23's admission record indicated, Resident 23 was readmitted to the facility on [DATE]. Review of Resident 23's physician orders indicated, Resident 23's siderail order was just created on 2/26/25. Resident 23 did not have a siderail order when it was initiated and used. 4i. During the observation of Resident 85 on 2/24/25 at 3:35 p.m., Resident 85 had his bilateral siderails up. Review of Resident 85's admission record indicated, Resident 85 was readmitted to the facility on [DATE]. Review of Resident 85's physician orders indicated, Resident 85's siderail order was just created on 2/26/25. Resident 85 did not have a siderail order when it was initiated and used. 4j. During the observation of Resident 106 on 2/23/25 at 12:42 p.m., Resident 106 had her bilateral siderails up. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of admission record of Resident 106 indicated, Resident 106 was readmitted to the facility on [DATE]. Review of the physician orders of Resident 106 indicated, the siderail order of Resident 106 was just created on 2/26/25. Resident 106 did not have a siderail order when it was initiated and used. 4k. During the observation of Resident 77 on 2/23/25 at 12:30 p.m., Resident 77 had his bilateral siderails up. Review of Resident 77's admission record indicated, Resident 77 was readmitted to the facility on [DATE]. Review of Resident 77's physician orders indicated, Resident 77's siderail order was just created on 2/26/25. Resident 77 did not have a siderail order when it was initiated and used. 4l. During the observation of Resident 27 on 2/23/25 at 12:35 p.m., Resident 27 had his bilateral siderails up. Review of Resident 27's admission record indicated, Resident 27 was readmitted to the facility on [DATE]. Review of Resident 27's physician orders indicated, Resident 27's siderail order was just created on 2/26/25. Resident 27 did not have a siderail order when it was initiated and used. 4m. During the observation of Resident 30 on 2/23/25 at 12:35 p.m., Resident 30 had his bilateral siderails up. Review of Resident 30's admission record indicated, Resident 30 was admitted to the facility on [DATE]. Review of Resident 30's physician orders indicated, Resident 30's siderail order was just created on 2/26/25. Resident 30 did not have a siderail order when it was initiated and used. 4n. During the observation of Resident 12 on 2/24/25 at 3:31 p.m., Resident 12 had her left siderail up. Review of Resident 12's admission record indicated, Resident 12 was admitted to the facility on [DATE]. Review of Resident 12's physician orders indicated, Resident 12's siderail order was just created on 2/26/25. Resident 12 did not have a siderail order when it was initiated and used. 4o. During the observation of Resident 74 on 2/23/25 at 12:40 p.m., Resident 74 had her bilateral siderails up. Review of Resident 74's admission record indicated, Resident 74 was admitted to the facility on [DATE]. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 74's physician orders indicated, Resident 74's siderail order was just created on 2/26/25. Resident 74 did not have a siderail order when it was initiated and used. 4p. During the observation of Resident 4 on 2/23/25 at 12:40 p.m., Resident 4 had her bilateral siderails up. Review of Resident 4's admission record indicated, Resident 4 was readmitted to the facility on [DATE]. Review of Resident 4's physician orders indicated, Resident 4's siderail order was just created on 2/26/25. Resident 4 did not have a siderail order when it was initiated and used. During the concurrent record review of the clinical records of Residents 21, 80, 302, 15, 40, 68, 94, 23, 85, 106, 77, 27, 30, 12, 74 and 4, and interview with the regional director of clinical services (RDCS), on 2/28/25 at 10:37 a.m., the RDCS verified that Residents 21, 80, 302, 15, 40, 68, 94, 23, 85, 106, 77, 27, 30, 12, 74 and 4, did not have side rail orders when their side rails were initiated and already used by the residents. Their side rail orders were just recently created. During the interview with the DON, on 2/28/25 at 5:35 p.m., the DON acknowledged the above findings and would check on these concerns. 44583 4q. During a concurrent interview with the RDCS and record review on 2/27/2025 at 10:06 a.m., the RDCS reviewed Resident 287's physician order and confirmed Resident 287 did not have an order for the use of bed rail prior to its installation and use. 4r. During a concurrent interview with the RDCS and record review on 2/27/2025 at 10:45 a.m., the RDCS reviewed Resident 66's physician order and confirmed Resident 66 did not have an order for use of bed rail prior to its installation and use. 4s. During a concurrent interview with the RDCS and record review on 2/27/2025 at 10:55 a.m., the RDCS reviewed Resident 13's physician order and confirmed Resident 13 did not have an order for use of bed rail prior to its installation and use. 4t. During an observation on 2/24/2025 at 10:36 a.m., inside Resident 299's room, Resident 299 was in bed, and there were two upper bed rails installed in her bed and in upright position. During a concurrent observation and interview with MDSC A on 2/27/2025 at 8:50 a.m., inside Resident 299's room, Resident 299 was in bed, with two upper bed rails installed in her bed and in upright position. MDSC A confirmed above observation. MDSC A stated after nurses have completed the bed rail assessment and determined resident had an indication to have bed rails, they should obtain a physician's order for bed rail use. During a concurrent interview with the RDCS and record review on 2/27/2025 at 11:08 a.m., RDCS reviewed Resident 299's physician order and confirmed Resident 299 did not have an order for use of bed rail prior to its installation and use. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	46001 4u. A review of Resident 53's admission record indicated Resident 53 was admitted to the facility on [DATE]. During an observation on 2/25/2025 with CNA O at 1:50 p.m., inside Resident 53's room. CNA O confirmed Resident 53's bed had two upper bed rails installed and both in upright position. During a concurrent interview and record review with the RDCS on 3/3/2025 at 11:05 a.m., the RDCS reviewed Resident 53's physician orders and confirmed that Resident 53's siderail order was just created on 2/26/25. The RDCS stated Resident 53 did not have a siderail order when it was initiated. During a review of the facility's policy and procedure titled, Bed Safety and Bed Rails, date revised 8/2022, indicated, The resident's sleeping environment is evaluated by the interdisciplinary team [IDT, a group of health care professionals from diverse fields who work toward a common goal for residents]. Consideration is give to the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment .The use of bed rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, inlcuding .interdisciplinary evaluation, resident assessment, and informed consent. Periodic evaluation and assessment on use of bed rails or side rails will be done (e.g. quarterly). During a review of the facility's undated policy and procedure titled, Careplans, Comprehensive Person-Centered, indicated, The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representatvie, develops and implements comprehensive, person-centered care plan for each resident .Assessments of residents are ongoing .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 46001 Based on interview and record review, the facility failed to provide sufficient nursing staff on a 24-hour basis based on the Staffing Data Report submitted to the Centers for Medicare & Medicaid Services (CMS). This failure could potentially affect resident's care, health, and psychosocial well-being. Findings: A record review of the facility's Direct Care Service Hours Per Patient Day (DHPPD) from July 2024 to January 2025 indicated that 63 days had actual DHPPD below 3.5. 5 days in July 2024 7/13/2024 Actual DHPPD 3.38; 7/20/2024 Actual DHPPD 3.04 ;7/21/2024 Actual DHPPD 3.10; 7/27/2024 Actual DHPPD 3.25; 7/28/2024 Actual DHPPD 3.41. 8 days in August 2024 8/3/22024 Actual DHPPD 3.29; 8/4/2024 Actual DHPPD 3.35;8/11/2024 Actual DHPPD 3.19; 8/17/2024 Actual DHPPD 3.45;8/18/2024 Actual DHPPD 3.38;8/24/2024 Actual DHPPD 3.21; 8/25/2024 Actual DHPPD 3.27; 8/31/2024 Actual DHPPD 3.34. 8 days in September 2024 9/7/2024 Actual DHPPD 3.21; 9/14/2024 Actual DHPPD 3.16;9/15/2024 Actual DHPPD 3.17 9/21/2024 Actual DHPPD 3.27; 9/22/2024 Actual DHPPD 3.39; 9/28/2024 Actual DHPPD 3.31 9/29/2024 Actual DHPPD 2.83; 9/01/2024 Actual DHPPD 3.01. 14 days in October 2024 10/10/2024 Actual DHPPD 3.31;10/11/2024 Actual DHPPD 3.48;10/12/2024 Actual DHPPD 2.83 10/13/2024 Actual DHPPD 2.95;10/14/2024 Actual DHPPD 3.43;10/15/2024 Actual DHPPD 3.43 10/17/2024 Actual DHPPD 3.35;10/18/2024 Actual DHPPD 3.12;10/19/2024 Actual DHPPD 2.45 10/20/2024 Actual DHPPD 2.43;10/21/2024 Actual DHPPD 3.45;10/22/2024 Actual DHPPD 3.49 10/23/2024 Actual DHPPD 2.52;10/26/2024 Actual DHPPD 3.34. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Cruz Post Acute	1115 Capitola Road Santa Cruz, CA 95062

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9 days in November 2024 11/2/2024 Actual DHPPD 3.33;11/6/2024 Actual DHPPD 2.68;11/17/2024 Actual DHPPD 3.13 11/23/2024 Actual DHPPD 3.11;11/24/2024 Actual DHPPD 3.32;11/25/2024 Actual DHPPD 3.33 11/28/2024 Actual DHPPD 2.64;11/29/2024 Actual DHPPD 2.61;11/30/2024 Actual DHPPD 2.62 11 days in December 2024 12/1/2024 Actual DHPPD 3.17;12/7/2024 Actual DHPPD 3.38;12/8/2024 Actual DHPPD 3.30 12/12/2024 Actual DHPPD 3.44;12/14/2024 Actual DHPPD 3.26;12/15/2024 Actual DHPPD 3.14 12/21/2024 Actual DHPPD 3.43;12/25/2024 Actual DHPPD 3.47;12/22/2024 Actual DHPPD 2.81 12/30/2024 Actual DHPPD 3.45;12/31/2024 Actual DHPPD 3.47. 7 days in January 2025 1/1/2025 Actual DHPPD 3.46;1/2/2025 Actual DHPPD 3.4;1/4/2025 Actual DHPPD 3.01 1/5/2025 Actual DHPPD 2.47;1/18/2025 Actual DHPPD 3.26;1/19/2025 Actual DHPPD 3.15 1/26/2025 Actual DHPPD 3.25. During a concurrent interview and record review with the Staffing Coordinator (SC) on 3/3/2025 at 1:58 p.m., the SC reviewed the DHPPD records from July 2024 to January 2025. The SC confirmed that the actual DHPPD for the above 63 days were below the required 3.5 and acknowledged past and ongoing staffing challenges. The SC stated that the Direct Care Service Hours Per Patient Day (DHPPD) should have been 3. 5. During an interview with the Administrator (ADM) on 3/3/2025 at 2:29 p.m., the ADM acknowledged that the facility had a workforce shortage waiver but stated that the facility should have provided no less than 3.5 direct care service hours per patient day. During a review of the facility's Certified Nursing Assistant (CNA) waiver from the California Department of Public Health (CDPH) dated June 18,2024 it indicated, Your request is approved, only as applicable to the required 2.4 CNA staffing standard, and valid from July 1, 2024, until June 30, 2025, under the following conditions .2. The facility shall provide no less than 3.5 direct care hours per patient day. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the All Facilities Letter (AFL) 21-11 dated March 17, 2021, indicated, The 3.5 DHPPD staffing requirement, of which 2.4 hours per patient day must be performed by CNAs, is a minimum requirement for SNFs (Skilled Nursing Facility). SNFs shall employ and schedule additional staff and anticipate individual patient needs for the activities of each shift, to ensure patients receive nursing care based on their needs. The staffing requirement does not ensure that any given patient receives 3.5 or 2.4 DHPPD; it is the total number of actual direct care service hours performed by direct caregivers per patient day divided by the average patient census.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 27000 Based on observation, interview, and record review, the facility failed to ensure the nursing staff demonstrated competency in the assessment and management of antihypertensive (medication to manage high blood pressure [BP]) and antiarrhythmic (medication to manage arrhythmia [abnormal or irregular heartbeats]) medications for 11 out of 40 sampled residents (Residents 10, 19, 38, 47, 60, 67, 72, 93, 104, 111, and 121). There were no documented BP and/HR before the medication administration, and physician's orders and prescribed hold parameters were not being followed. The failure had the potential for residents to suffer from undetected severe hypotension (low BP) and worsening of arrythmias. Also, the facility failed to ensure all nursing staffs were checked off their competencies to provide nursing care and medication pass trainings to assure resident safety, when one of five nurses reviewed did not have a record that she was checked off on nursing care competencies and medication pass trainings. The failure had the potential to compromise the safety of the residents and not attaining or maintaining their highest practicable physical, mental, and psychosocial well-being. Findings: 1a. During a medication pass observation on 2/24/25 at 9:33 a.m., LVN C was observed preparing and administering 8 medications, including a tablet of losartan 50 mg, to Resident 47. During the concurrent interview and record review on 2/24/25 at 9:52 a.m., when asked about Resident 47's BP for the administration of losartan, LVN C stated a certified nursing assistant (CNA) had already taken it earlier that day. She reviewed Resident 47's clinical record which indicated the latest BP was obtained the day prior, on 2/23/25 at 16:08 (4:08 p.m.). LVN C stated she did not check the resident's BP earlier that morning. On 2/24/25 at 9:54 a.m., she returned to Resident 47's bedside and obtained her BP. It was 156/70 mmHg (normal BP is under 120/80 mmHg). After returning to the medication cart, LVN C stated, It was a mistake and she should have checked the BP before giving the losartan. A review of Resident 47's clinical record indicated a physician's order, dated 5/21/24, for losartan 50 mg, give 1 tablet one time a day for hypertension hold for systolic [BP] <110 [mmHg]. 1b. For Resident 104, he had the following physician's orders: - Valsartan (treat high blood pressure and heart failure) 40 mg 1 tablet twice daily for hypertension, dated 4/12/24. On 1/30/25, valsartan was discontinued and switched to Entresto (combination of valsartan and sacubitril, another antihypertensive medication) 24-26 mg twice daily. One 2/4/25, Entresto was reduced to one time a day for hypertension. Part of its order indicated to Check BP without specified frequency. Each of these medications was scheduled to be administered daily at 10 a.m. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Furosemide 20 mg, give 1.5 tablets (30 mg) one time a day for edema (swelling caused by a buildup of fluid in body tissues) and hypertension, dated 8/23/24. It was scheduled to be administered daily at 9 a.m. - Spironolactone 25 mg, give 1 tablet one time day for fluid retention, dated 12/26/24. It was scheduled to be administered daily at 9 a.m. - Metoprolol extended release (ER) 25 mg one time a day for hypertension, hold for systolic BP < [less than] 100 [mmHg], [HR] <60 [bpm], dated 4/12/24. It was scheduled to be administered daily at 10 a.m. (Normal HR is between 60 - 100 bpm). B. Amiodarone 200 mg, 1 tablet by mouth one time a day for arrhythmia, dated 4/12/24. It was scheduled to be administered daily at 10 a.m. C. Check BP Q [every] day one time a day 'call clinic if SBP is less than 100 [mmHg] consistently, dated 1/30/25. It was scheduled daily at 9 a.m. A review of Resident 104's January and February 2025 MARs indicated the nursing staff placed their initials and a check mark on in the entry for the Check BP one time a day without corresponding BP readings. There were no corresponding BP readings for the administration of furosemide, valsartan or Entresto, and spironolactone. Similarly, there was no documentation of corresponding BP and HR for the administration of metoprolol despite the physician's order to hold for SBP <100 mmHg and HR <60 bpm. Furthermore, there was no hold parameters for or corresponding measurement of BP and HR for the use of amiodarone. Further review of Resident 104's BP and HR summary indicated there were periods of BP and HR as long as 14 days: 1/11/25 to 1/26/25. During a concurrent interview and record review with the Director of Nursing (DON), the Infection Control Preventionist (IP), and Nurse Supervisor D (NS D) on 2/27/25 at 1:45 p.m., they reviewed Resident 104's clinical record and acknowledged the resident's BP and HR were not checked on a daily basis as per physician's order, and before administration of metoprolol; no BP checks done before the administration of Entresto, spironolactone, and furosemide; no hold parameters; and no BP and HR check for amiodarone . The IP and NS D stated the BP and HR should be checked at least daily. The DON, the IP, and NS D also verified there were gaps of multiple days where BP and HR were not checked daily and acknowledged the potential for resident to suffer from undetected severe hypotension and arrhythmias (such as too slow HR). During an interview with the DON on 2/27/25 at 4:33 p.m., she stated, The blood pressure and pulse were not consistently done . The MAR was not coded right so it's not on the MAR. She explained the MAR should be coded to require an input of the BP and/or HR with BP and cardiac (heart) medications. On 2/28/25 at 9:26 a.m. in the presence of the Assistant Director of Staff Development (ADSD), a review of Resident 104's February 2025 MAR with LVN G indicated she administered the metoprolol with the prescribed hold parameters, and documented she checked the BP on 2/5 and 2/6/25; however, there was no BP and HR measurement in the clinical record for both days. Both LVN G and the ADSD verified this finding. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review with LVN H on 2/28/25 at 9:42 a.m., she reviewed with the surveyor Resident 104's February 2025 MAR and confirmed she documented the administration of metoprolol with ordered hold parameters, and did the daily BP on 2/25/26; however, there were no BP and HR measurement on 2/25/26 in Resident 104's clinical record. She stated, If the MAR doesn't say then I don't put in there unless I put in the progress notes. When asked to look up the progress notes, LVN H stated, I know I did not. During a concurrent interview and record review with LVN I on 2/28/25 at 9:55 a.m., a review of Resident 104's February 2025 MAR with LVN I indicated she documented she administered the metoprolol and did the daily BP check on 2/10, 2/11, 2/15, and 2/21/25 during which there were no documentation of daily BP and HR measurement. She stated, I checked them but not entered into the system because it didn't have entry to enter, but I always check them. In a concurrent interview and record review with Registered Nurse (RN) J on 2/28/25 at 10:11 a.m., a review of Resident 104's February 2025 MAR with RN J indicated she administered the BP medications, including the metoprolol; and the daily BP check, on 2/3, 2/4, 2/14, 2/22, 2/23, and 2/26/25 during which there were no BP and HR measurement in the clinical record. RN J acknowledged there were BP and HR missing in the MAR and stated, I understand what you are saying. There's no excuse for it. She also acknowledged Resident 104 was receiving four BP medications which had the potential for severe hypotension if not checked. She stated the nurses can change the order when the MAR did not have entries to input BP and HR, but acknowledged they were not done prior to being brought up by the survey team (on 2/27/25). 1c. Digoxin is an antiarrhythmic agent to treat heart failure and atrial fibrillation (AF; condition where the upper chambers of the heart [atria] beat irregularly and rapidly). A. A review of Resident 38's clinical record indicated the resident had a physician's order for Digoxin Tablet 250 MCG [micrograms, unit of measurement], Give 1 tablet by mouth one time a day for heart failure check apical heart rate [or apical pulse or AP; heartbeat that is felt or heard at the apex (bottom) of the heart, typically on the left side of the chest] prior to each dose. Hold dose if heart rate is less than 60 [bpm] and notify MD [medical doctor], dated 1/5/25. On 2/28/25 starting at 2:32 p.m., a review of Resident 38's January and February 2025 MARs with Minimum Data Set Coordinator B (MDSC B) indicated the nursing staff did not hold the resident's digoxin when he had the documented pulse (HR) of less than 60 bpm on: 1/20 (HR: 58); 1/26 (HR: 53); on 2/3 (HR: 59), on 2/5 (HR: 53), 2/7 (HR: 55), and 2/18/25 (HR: 59). MDSC B also reviewed the progress notes and stated there was no physician's notification on those days. She confirmed the physician's order was not followed. B. On 2/28/25 at 2:40 p.m., a review of Resident 111's clinical record with MDSC B indicated Resident 111 had a physician's order for Digoxin Oral Tablet 125 MCG . Give 1 tablet by mouth one time a day for Antiarrhythmic Hold if APICAL pulse <60 [bpm], dated 6/28/24. A review of Resident 111's February 2025 MAR indicated digoxin was documented as administered to the resident on 2/26/25, but there was no documented AP on that day. MDSC B verified this finding . (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. On 2/28/25 at 2:44 p.m., a review of Resident 10's clinical record indicated he had been receiving Digoxin Tablet 125 MCG Give 1 tablet by mouth one time a day for heart failure Hold dose if AP less than 60 [bpm] since 4/24/2021. He also had a physician's order, dated 4/1/24, for laboratory blood tests including the digoxin level every 3 months, scheduled January, April, July, and October each year. MDSC B reviewed Resident 10's clinical record along with the contracted laboratory website, and stated she could only found one laboratory report conducted on 4/1/24. She confirmed there was no digoxin level done in July 2024, October 2024, or in January 2025. She acknowledged the physician's order was not carried out. 1d. A review of the Package Insert (PI, document included in the package of a medication that provides information about that drug and its use) for amiodarone, revised 10/2018, indicated it an antiarrhythmic medication to treat ventricular arrhythmias (life-threatening heart rhythm disturbance where the ventricles [lower chambers of the heart] quiver instead of contracting normally) and atrial fibrillation. The PI also indicated to monitor the patient's cardiac [heart] rhythm and blood pressure, and, if bradycardia ensues, a B-adrenergic agonist [a type of medication to increase HR] or a pacemaker may be used . A. Review of Resident 121's physician order, dated 12/20/2024, indicated, Amiodarone . 100 MG Give 1 tablet by mouth one time a day for CHF [chronic heart failure, a condition where the heart can't pump enough blood to meet the body's needs]. Amiodarone was scheduled to be given daily at 9:00 a.m. During a concurrent interview with the Assistant Director of Staff Development (ADSD) and record review of Resident 121's physician's order and February 2025 MAR on 2/28/25 at 3:35 p.m., the ADSD confirmed there was no documented BP and HR readings in the MAR from 2/1 to 2/27/25 prior to administration of amiodarone. During a follow-up interview with MDSC B on 2/28/25 at 3:58 p.m., MDSC B stated nurses should check and document Resident 121's BP and HR prior to administration of amiodarone. Review of Resident 121's blood pressure summary (undated) indicated Resident 121 had documentation of systolic BP of less than 110 mmHg as follows: BP: 108/78 on 2/1/25 at 9:04 a.m.; BP: 108/59 on 2/8/25 at 4:25 p.m.; and BP 91/62 on 2/9/25 at 1:46 a.m. B. Review of Resident 60's physician order, dated 2/1/25, indicated, Amiodarone . 200 MG Give 1 tablet by mouth one time a day for abnormal heart rhythm. Amiodarone was scheduled to be given daily at 9:00 a.m. During a concurrent interview with MDSC B and record review on 2/28/25 at 4:05 p.m., MDSC B reviewed Resident 60's physician order and the February 2025 MAR, and confirmed there was no documentation of Resident 60's BP and HR prior to administration of amiodarone from 2/1 to 2/28/25. Review of Resident 60's BP summary indicated Resident 60 had systolic BP less than 110 as follows: BP: 105/63 on 2/6/25 at 5:37 p.m.; BP: 105/70 on 2/20/25 at 4:18 p.m.; BP: 90/60 on 2/23/25 at 6:13 p.m.; BP 103/62 on 2/24/25 at 6:52 p.m.; and BP: 107/62 on 2/27/25 at 4:46 p.m. C. Review of Resident 67's physician order, dated 11/17/2020, indicated, Amiodarone . 200 MG Give 1 tablet by mouth one time a day for Arrythmia. Amiodarone was scheduled to be given daily at 9:00 a.m. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview with MDSC B and record review on 2/28/25 at 4:21 p.m., MDSC B reviewed Resident 67's physician order and February 2025 MAR, and confirmed nurses did not check Resident 67's BP and HR prior to administration of amiodarone from 2/1 to 2/27/25. D. Review of Resident 72's physician order, dated 2/11/25, indicated, Amiodarone .100 MG Give 1 tablet by mouth one time a day for bradycardia. Amiodarone was scheduled to be given daily at 9:00 a.m. During a concurrent interview with MDSC B and record review of Resident 72's physician order and February 2025 MAR on 2/28/25 at 4:26 p.m., MDSC B confirmed nurses did not obtain and document Resident 72's BP and HR prior to medication administration from 2/12 to 2/27/25. Further review of Resident 72's February 2025 MAR revealed Resident 72 had an order of 200 mg of amiodarone, dated 1/28/25, with parameter indicated, Hold for SBP less than 110 [mmHg] or HR less than 60 [bpm] The following was revealed: on 2/5/25, Resident 72's BP was 90/61, amiodarone was documented as given; on 2/6/25, Resident 72's BP was 105/73 with HR of 50 bpm, amiodarone was documented as given; and on 2/11/25, Resident 72's BP was 102/66, amiodarone was marked as given. During a concurrent interview with MDSC B and record review of Resident 72's February 2025 MAR on 2/28/25 at 4:26 p.m., MDSC B reviewed Resident 72's February 2025 MAR and confirmed amiodarone was given on 2/28/25 with BP of 95/87. MDSC B confirmed the nurse did not follow the parameters ordered by the physician. E. A review of Resident 19's physician order, dated 8/19/24, indicated for amiodarone 100 mg give 1 tablet by mouth one time a day for arrhythmia. Hold for SBP less than 110 or heart rate (HR) less than 60. The start date was 8/19/24. During a concurrent interview and record review of Resident 19's clinial record with the DON on 2/28/25, at 5:23 p.m., the DON reviewed Resident 19's physician order and MARs for December 2024, January, and February 2025. The DON confirmed no BP or HR readings were documented in the MAR from 12/1/24 to 2/27/25 prior to the administration of amiodarone. A review of Resident 19's BP summary from 1/26/25 to 2/28/25 indicated that Resident 19 had SBP less than 110: BP: 96/54 on 2/14/25 at 1:14 p.m.; BP: 95/51 on 2/27/25 at 7:30 p.m. A review of Resident 19's pulse summary from 1/2/25 to 2/28/25 indicated six instances of a recorded pulse rate (PR) below 60 in January 2025 and in February 2025, as follows: Date and time PR/ HR reading (bpm) 1/07/25 18:18 58 1/09/25 16:34 57 1/25/25 16:51 55 1/25/25 16:52 55 1/26/25 16:15 59 (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/08/25 17:25 55 F. A review of Resident 38's physician order dated 1/4/25 indicated, Amiodarone . 200 MG Give 1 tablet by mouth two times a day for abnormal heart rhythm. Hold for SBP less than 110 or heart rate less than 60. The start date was 1/4/25. During a concurrent interview and record review of Resident 38's clinical record with the DON on 2/28/25, at 5:25 p.m., the DON confirmed that no BP or HR readings were documented in the MAR from 1/4/25 to 1/31/25 prior to the administration of amiodarone. A review of Resident 38's pulse rate summary from 1/4/25 to 2/28/25, indicated 15 recorded pulse rates below 60 in January 2025 and 16 instances in February 2025. G. A review of Resident 93's physician order, dated 2/3/25, indicated for amiodarone 200 mg, Give 1 tablet by mouth two times a day for abnormal heart rhythm. Hold for SBP less than 110 or heart rate less than 60. The start date was 2/3/25. During a concurrent interview and record review of Resident 93's clinical record with DON on 2/28/25, at 5:27 p.m., the DON reviewed Resident 93's physician order and the February 2025 MAR, and confirmed that no BP or HR readings were documented in the MAR from 2/4 to 2/27/25 before the administration of amiodarone. A review of Resident 93 's pulse rate summary indicated Resident 93 had a pulse rate below 60, which was 52 bpm on 2/9/25. A review of the facility's policy and procedures (P&P) titled Medication Administration, revised 4/2019, it indicated, Medications are administered in accordance with prescribers orders . The following information is checked/verified for each resident prior to administering medications . Vital signs, if necessary. 44185 2. During the medication pass observation on 2/24/25 at 9:17 a.m., Licensed Vocational Nurse C (LVN C), was observed giving medications to Resident 6. On 2/24/25 at 9:33 a.m., LVN C was also observed administering medications for Resident 47. Review of the facility's records of five nursing staffs' competency checks and medication pass trainings indicated, LVN C did not have a record that she was checked of her nursing care competencies and medication pass trainings. During an interview with the regional director of clinical services (RDCS) on 2/28/25 at 3:40 p.m., RDCS verified that the facility did not have a record that LVN C was checked of her nursing care competencies and medication pass trainings. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy and procedure titled, Staffing, Sufficient and Competent Nursing, dated 2001, indicated, Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment . Licensed nurses .to provide competent resident care services including . attaining or maintaining the highest practicable physical, mental and psychosocial well-being of each resident .assessing, evaluating, planning and implementing resident care plans . Competent staff .must demonstrate the skills and techniques necessary to care for resident needs including . Basic nursing skills . Competency requirements and training for nursing staff are established and monitored by nursing leadership with input from the medical director .

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Santa Cruz Post Acute	1115 Capitola Road Santa Cruz, CA 95062

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 27000 Based on observation, interview, and record review, the facility failed to ensure the provision of pharmaceutical services that included availability of medication, accurate and safe administration of medications, and accurate accountability of controlled substance (that can be easily abused and are under strict government control) when: 1. A medication was not available to administer to Resident 296 for 10 days, and the nursing staff failed to follow up with the pharmacy or notify the physician of the missing medication. This had the potential for untreated and worsening of the resident's medical condition. 2. Two non-crushable medications for Resident 296 were crushed during administration. This had the potential for the resident to suffer from adverse effects of the medications due to too fast delivery of the medication. 3. There was no person-centered, individualized approach for administering medications for Resident 6 who has trouble swallowing medications. This resulted in one of her medications being crushed and not meeting her needs. 4. For Resident 297, the facility did not have a system to ensure weekly narcotic patch was in place to ensure continued delivery of the medication and to prevent abuse of medication. 5. Controlled medications were not reconciled for 4 out of 6 residents (Residents 39, 81, 287, 294). This resulted in facility not having an accurate accountability and the potential for abuse/loss of controlled medications. Findings: 1. During a medication administration observation on 2/24/25 at 8:44 a.m. with Registered Nurse F(RN F), she stated she could not find Steglatro (oral medication to lower blood sugar levels in people with diabetes) to administer to the Resident 296. A review of Resident 296's clinical record indicated a physician's order, dated 1/30/25, for Steglatro Oral Tablet 5 MG . Give 1 tablet by mouth one time a day for diabetes. A review of Resident 296's February 2025 Medication Administration Record (MAR) indicated the nursing staff documented a 9 (meaning Other/See Nurses Notes) in the Steglatro entry on 2/9 - 2/13/25; 2/15 - 2/17/25; 2/19-2/20/25; and 2/24/25 (a total of 10 days). A review of the corresponding Nurses Notes for the above dates indicated: - 2/9/25 at 10:31 a.m. - medication not available. pending insurance clarification - 2/10/25 at 9:45 a.m. - waiting delivery (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 2/11/25 8:10 a.m. - on order - 2/12/25 8:48 a.m. - reordered from pharmacy - 2/13/25 8:47 a.m.- reordered from pharmacy - 2/15/25 8:59 a.m.- on delivery - 2/1724 8:53 a.m.- - not available - 2/19/25 8:43 a.m.- no notes - 2/20/25 8:08 a.m.- No notes - 2/24/25 9:03 a.m. medication is not covered by insurance; recommendation for alternative faxed to be addressed with MD [medical doctor] - 2/24/25 9:26 a.m. - Note Text: Pharmacy informed staff that Steglatro not covered by insurance and to consider alternative Farxiga [medication for diabetes]. Dr. [name] made aware and medication changed as per pharmacy recommendation. During a concurrent interview and record review with Nursing Supervisor D (NS D) on 2/24/25 at 2:06 p.m., she stated she called the pharmacy and was informed they sent a 2-week and a 3-day supply since the order date on 1/30/25. She was just informed by the pharmacy this morning that the medication was not covered by the insurance, and the pharmacy recommended an alternative medication. NS D reviewed Resident 296's clinical record and February 2025 MAR. She confirmed the resident missed 10 days of the medication, and there was no documented evidence the staff called the pharmacy to follow up and informing the physician of the missing medication. A review of the facility's policy and procedures titled Pharmacy Services Overview, dated 4/2019, indicated: 4. Residents have sufficient supply of their prescribed medications and receive medications (routine, emergency or as needed) in a timely manner. 5. Nursing staff communicate prescriber orders to the pharmacy and are responsible for contacting the pharmacy if a resident's medication is not available for administration. 2. During the medication administration observation with RN F above, on 2/24/25 at 8:43 a.m., RN F was observed preparing 9 medications, including a tablet of metoprolol (medication to to treat high blood pressure) extended release (ER, medication is formulated so that the drug is released slowly over time) 25 milligrams (mg, unit of measurement), to give to Resident 296. RN F was observed crushing all the tablets and poured the crushed contents into a medicine cup. RN F stated Resident 296, likes them all crushed together. RN F added a spoonful of yogurt to the crushed powder and spoon-fed the mixture to Resident 296 at his bedside. During an interview on 2/24/25 at 9:02 a.m., RN F stated that metoprolol ER shouldn't be crushed, but it was. A review of Resident 296's physician orders included the following: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Metoprolol Succinate ER tablet 25 mg, give 1 tablet by mouth one time a day for high blood pressure, dated 1/30/25 - Protonix tablet delayed release 40 mg, give 1 tablet by mouth one time a day for acid indigestion, start date 1/30/25. A review of drug resource, DailyMed (https://dailymed.nlm.nih.gov), indicated, Metoprolol succinate extended-release tablets are scored on both sides and can be divided; however, do not crush or chew the whole or half table and Do not split, crush, or chew PROTONIX For Delayed-Release Tablets. During an interview with Resident 296 on 2/25/25 at 9:01 a.m., he stated his medications are crushed, all the time. Resident 296 stated that he does not remember the reason his medications are crushed, but said he likes them crushed. During another interview with RN F on 2/25/25 at 9:08 a.m. RN F stated that Resident 296, always takes his meds crushed. RN F acknowledged metoprolol ER should not be crushed due to being extended released. During a concurrent interview and record review with NS D and RN F on 2/25/25 at 9:15 a.m., RN F stated Resident 296 would chew the medications if given in whole tablets. RN D acknowledged the Metoprolol ER and Protonix tablets are not crushable. During an telephone interview with the Consultant Pharmacist (CP) on 2/27/25 at 11:21 a.m., he stated metoprolol ER and Protonix tablets cannot be crushed. A review of the facility's policy titled, Crushing Medications, revised April 2018, indicated Medications shall be crushed only when it is appropriate and safe to do so, consistent with physician orders 1. The medical director and director of nursing services, in conjunction with the consultant pharmacist, shall identify appropriate indications and procedures for crushing medications. 3. During a medication administration observation on 2/24/25 at 9:17 a.m., Licensed Vocational Nurse (LVN) C was observed preparing four medications for Resident 6. The medications included a tablet of potassium chloride (to treat low potassium level in the blood) ER 20 milliequivalents (mEq, a unit of measure). On 2/24/25 at 9:22 a.m., at Resident 6's bedside, LVN C was observed administering the medications to Resident 6, in whole pills, with applesauce. The resident swallowed the applesauce but not the medications. She pushed the large pills out of her mouth using her tongue. LVN C took the rejected pills from the resident's mouth. On 2/24/25 at 9:26 a.m., LVN C returned to the medication cart and stated the rejected medications were the potassium ER tablet, a Tylenol 500 mg tablet, and docusate sodium (stool softener) 250 mg tablet. She disposed of the medications and retrieved new ones from the medication cart, crushed them into a fine powder, and mixed with applesauce. On 2/24/25 at 9:29 a.m., LVN C returned to Resident 6's bedside and administered the medication-applesauce mixture to the resident. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview with LVN C at 2/24/25 at 10:02 a.m. and a review of the pharmacy label for potassium ER 20 mEQ tablet indicated its manufacturer is Manufacturer A, and a warning label indicating May be Broken or Allowed to Disintegrate In Water (Stir Well) Before Swallowing. Rinse Down With Water, But Do Not Chew, All of The Remaining Particles. LVN C acknowledged it should not be crushed. A review of Manufacturer A's drug information for potassium chloride ER tablet, revised 3/2023, indicated, To take each dose without crushing, chewing or sucking the tablets. A review of Resident 6's clinical record indicated a physician's order, dated 2/23/24, for Potassium Chloride ER Tablet Extended Release 20MEQ Give 1 tablet by mouth one time a day for supplement. During concurrent interview and record review with another nurse, LVN H, on 2/25/25 at 1:46 p.m., she confirmed she crushed and administered the potassium ER tablet to Resident 6 earlier this morning. LVN H stated the pharmacy label indicated it could be dissolved in water, so she thought it could be crushed. A review of Resident 6's clinical record indicated no care plans for swallowing or whether or not medications were to be crushed. There was no swallowing evaluation identified. During an interview with the Director of Staff Development (DSD) on 2/25/25 at 1:55 p.m., she stated, The doctor told us that you could mix the [potassium] tablet with water, but it takes forever. The DSD also stated Resident 6 had a regular nurse in the past who knew how to give her the potassium tablet, but with registry nurses, they may not know how to give it to her. During a telephone interview with the CP on 2/27/25 at 11:21 a.m., he stated potassium ER tablet should not be crushed. A review of the facility's policy titled, Crushing Medications, revised April 2018, indicated Medications shall be crushed only when it is appropriate and safe to do so, consistent with physician orders . 1. The medical director and director of nursing services, in conjunction with the consultant pharmacist, shall identify appropriate indications and procedures for crushing medications. 2. The nursing staff and/or consultant pharmacist shall notify any attending physician who gives an order to crush a drug that the manufacturer states should not be crushed a. The attending physician or consultant pharmacist must identify an alternative medication and/or dosage form . 4. A review of Resident 297's clinical record indicated she was admitted to the facility with diagnoses including fracture of the right pubis (flat, triangular bone that forms the front part of the right hip bone and pelvis). Her Minimum Data Set (MDS, a care area assessment and screening tool), dated 2/25/25, indicated she had a BIMS score of 10 (Brief Interview for Mental Status, a test given by medical professionals that helps determine a patient's cognitive understanding, scored from 1 to 15), which indicated his cognitive condition was moderately impaired. Resident 297 had a physician's order, dated 2/23/25, for Buprenorphine Transdermal Patch [a narcotic skin patch used to treat severe and persistent pain that requires an extended treatment period] Weekly 5 MCG/HR [micrograms per hour] Apply 1 patch transdermally in the morning every 7 day(s) for pain and remove per schedule. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Resident 297 at her bedside on 2/26/25 at 2:35 p.m., when asked about her buprenorphine patch, Resident 297 stated a physician at the hospital applied it on her before she left the hospital. She uncovered her left neckbone/upper chest to show the surveyor the patch but it was not there. She stated it does not work for her but it was there before arriving to the facility. She stated she had a shower yesterday and it may have fallen off during the shower. During a concurrent interview and record review with LVN K on 2/26/25 at 2:38 PM, LVN K reviewed Resident 297's clinical record and confirmed the resident arrived with a hospital-applied patch on 2/21/25. During another interview with Resident 297 in the presence of LVN K on 2/26/25 at 2:46 p.m., Resident 297 stated she had a new patch applied by the hospital doctor before arriving in the facility. She had a shower yesterday and she did not know what happened to the patch as she had forgotten about it. During another interview with LVN K on 2/26/25 at 2:59 p.m., when asked if there was a system of daily checking of patch placement for weekly patch such as buprenorphine, LVN K stated there was no such thing as she has been here for 2 years. She said it would make sense to have such system for narcotic patches. During an interview with NS D on 2/26/25 at 3:39 p.m., she stated currently there was no process for daily patch placement check but there should be. NS D acknowledged lost or misplaced narcotic patch would result in disruption in delivery of the medication which would lead to uncontrolled pain management, and the potential for abuse/misuse. A review of the Prescribing Information for buprephenone patch, revised June 2014, indicated the patch is intended to be worn for 7 days . If your patch falls off later, but before 1 week (7 days) of use, throw it away properly . and apply a new patch at a different skin site. 5. During the survey, the controlled drug record (CDR, an inventory sheet) for 6 residents receiving PRN (as needed) controlled (narcotic) medications was requested for review. During an interview with the DON on 2/25/25 at 11:53 a.m., she stated any time a resident requests a PRN narcotic medication, the nurse assesses the resident, checks the physician's order and reads the instructions in the computer, removes the medication from the narcotic drawer, administers the medication to the resident, and documents the administration on the MAR. On 2/25/25 starting at 12 noon, during a concurrent interview and record review with the DON and the Medical Record Director (MRD), they verified the following: a. Resident 39 had a physician's order, dated 7/22/24, for Norco (a combination of hydrocodone with acetaminophen, a narcotic for pain) 5-325 mg, 1 tablet every 6 hours as needed for pain. A review of Resident 39's CDR for Norco 5-325 mg and the October 2024 MAR with the two staff indicated a nursing staff removed 1 tablet of Norco on 10/2/24 at 1 p.m. without documenting the administration on the MAR. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Resident 294 had a physician's order, date 2/4/25, for Norco 5-325 mg, give 1 tablet by mouth every 4 hours as needed for severe pain. A review of Resident 294's CDR for Norco 5-325 mg and February 2025 MAR with the two staff indicated, on 2/22/25 at 10 a.m., a nursing staff removed 1 tablet from the CDR without documenting the administration on the MAR. c. Resident 287 had a physician's order for Norco 5-325 mg,1 tablet by mouth every 6 hours as needed for moderate pain, start date 2/13/25. A review of Resident 287's CDR for Norco 5-325 mg and the February 2025 MAR with the DON and the MRD indicated, on 4 occasions, the nursing staff removed the medication and signed out of the CDR but did not document the administration on the MAR: on 2/14/25 at 3:26 p.m. and 9:40 p.m.; on 2/15/25 at 0050 a.m. ; and on 2/20/25 at 2:49 p.m. d. Resident 81 had a physician's order for oxycodone (a potent narcotic for pain) 10 mg, 1 tablet by mouth every 6 hours as needed for severe pain, start date 1/24/25. A review of Resident 81's CDR for oxycodone 10 mg and the February 2025 MAR with the DON and MRD showed, on 6 occasions, the nursing staff signed out of the CDR but did not document the administration on the MAR: on 2/14/25 at 3:42 p.m. and 10:59 p.m.; on 2/16/25 at 9 p.m.; on 2/19/25 at 11:20 a.m. and 11 p.m. ; and on 2/22/25 at 1 p.m. During the interview and record review above, on 2/25/25 at 12:20 p.m., the DON confirmed the above findings and stated the facility has been made aware of this issue during the survey, and started the in-service with the nursing staffs. She confirmed the controlled medications for these four residents were not fully accounted for. A review of the facility's P&P titled, Medication Administration, revised April 2019, indicated in part, . the individual administering the medication records in the resident's medical record: a. The date and time of the medication was administered . g. The signature and title of the person administering the drug.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 27000 Based on observation, interview, and record review, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported irregularities during the monthly medication regimen review (MRR) for 7 out of 34 sampled residents (10, 38, 54, 104, 111, 121, and 287) and one non-sampled Resident 296. Also, the facility failed to respond to the CP's recommendation for Resident 296. This failures resulted in unnecessary medications for the residents including duplicate therapy and inappropriately monitored medication use for the residents. Findings: 1. During the medication administration observation with RN F above, on 2/24/25 at 8:43 a.m., RN F was observed preparing 9 medications, including a tablet of metoprolol (medication to to treat high blood pressure) extended release (ER, medication is formulated so that the drug is released slowly over time) 25 milligrams (mg, unit of measurement), to give to Resident 296. RN F was observed crushing all the tablets and poured the crushed contents into a medicine cup. RN F stated Resident 296, likes them all crushed together. During an interview on 2/24/25 at 9:02 a.m., RN F stated that metoprolol ER shouldn't be crushed, but it was. A review of Resident 296's physician orders included the following: - Metoprolol Succinate ER tablet 25 mg, give 1 tablet by mouth one time a day for high blood pressure, dated 1/30/25 - Protonix tablet delayed release 40 mg, give 1 tablet by mouth one time a day for acid indigestion, start date 1/30/2025. - May crush medications (or open capsules) as indicated per pharmacy protocol, dated 1/29/2025. A review of drug resource, DailyMed (https://dailymed.nlm.nih.gov), indicated, Metoprolol succinate extended-release tablets are scored on both sides and can be divided; however, do not crush or chew the whole or half tablet and Do not split, crush, or chew PROTONIX For Delayed-Release Tablets. During an interview with Resident 296 on 2/25/25 at 9:01 a.m., he stated his medications are crushed, all the time. Resident 296 stated that he does not remember the reason his medications are crushed, but said he likes them crushed. During a concurrent interview and record review with NS D and RN F on 2/25/25 at 9:15 a.m., RN F stated Resident 296 would chew the medications if given in whole tablets. RN D acknowledged the Metoprolol ER and Protonix tablets are not crushable. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an telephone interview with the Consultant Pharmacist (CP) on 2/27/25 at 11:21 a.m., he stated he reviewed the residents' medication regimen from 2/1 to 2/3/25 for this month. He stated metoprolol ER and Protonix tablets cannot be crushed. Given Resident 296's order for may crush medications, the CP was asked if he made a recommendation for the staff not to crush the metoprolol and Protonix during the February 2025 MRR, he stated he did not but will pay more attention in the future. 2. A review of Resident 296's clinical record indicated he had physician's orders for two medications, Protonix and omeprazole (both belong to medication class called proton pump inhibitors, to treat acid reflux), as follows: - Protonix tablet delayed release 40 mg, give 1 tablet by mouth one time a day for acid indigestion, start date 1/30/25. - Omeprazole 20 mg, 1 tablet by mouth one time a day for gastric indigestion, dated 1/30/25. Both medications were ordered on the same day and scheduled to be administered at the same time, at 6 a. m. During a telephone interview with the CP on 2/27/25 at 11:21 a.m., he reviewed his own record and stated the pharmacy made a recommendation to discontinue omeprazole on 1/30/25, the day the orders were made. The CP stated he did not know what happened to the recommendation. During a concurrent interview and record review with the Director of Nursing (DON), the Infection Control Preventionist (IP), and Nurse Supervisor D (NS D) on 2/27/25 at 1:45 p.m., the IP provided the said recommendation from the pharmacy, dated 1/30/25, which read, The use of the above GI [gastrointestinal] medications [omeprazole and Protonix] may be considered duplicate therapy and contribute to polypharmacy and unnecessary medication use with an increased risk of side effects. RECOMMENDATION: Please consider discontinuing omeprazole. The IP stated the Assistant DON is responsible for following up all the recommendations from the CP, but she was not available for interview. The DON acknowledged this recommendation was not acted upon as Resident 296 continued to receive duplicate therapy until it was brought up by the surveyor today (almost a month later.) 3. A review of Resident 104's admission record indicated he was admitted to the facility with diagnoses including pleural effusion (condition where excess fluid accumulates in the pleural space, the thin cavity between the lungs and the chest wall), heart failure, pulmonary edema (condition where excess fluid accumulates in the lungs, causing difficulty breathing), and unspecified peripheral vascular disease (slow and progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel). On 2/27/25, a review of Resident 104's physician's orders, and January and February 2025 MARs, indicated the following orders and administration times: A. Four routine antihypertensive (to lower BP) medications: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Valsartan (treat high blood pressure and heart failure) 40 mg 1 tablet twice daily for hypertension, dated 4/12/24. On 1/30/25, valsartan was discontinued and switched to Entresto (combination of valsartan and sacubitril, another antihypertensive medication) 24-26 mg twice daily. One 2/4/25, Entresto was reduced to one time a day for hypertension. Each of these medications was scheduled to be administered daily at 10 a. m. - Furosemide 20 mg, give 1.5 tablets (30 mg) one time a day for edema (swelling caused by a buildup of fluid in body tissues) and hypertension, dated 8/23/24. It was scheduled to be administered daily at 9 a.m. - Spironolactone 25 mg, give 1 tablet one time day for fluid retention, dated 12/26/24. It was scheduled to be administered daily at 9 a.m. - Metoprolol extended release (ER) 25 mg one time a day for hypertension, hold for systolic BP < [less than] 100 [mmHg], [HR] <60 [bpm], dated 4/12/24. It was scheduled to be administered daily at 10 a.m. (Normal HR is between 60 - 100 bpm). B. Amiodarone (medication to manage irregular or abnormal heart rhythms) 200 mg, 1 tablet by mouth one time a day for arrhythmia, dated 4/12/24. It was scheduled to be administered daily at 10 a.m. C. Check BP Q [every] day one time a day 'call clinic if SBP is less than 100 [mmHg] consistently, dated 1/30/25. It was scheduled daily at 9 a.m. A review of the Package Insert (PI, document included in the package of a medication that provides information about that drug and its use) for amiodarone, revised 10/2018, indicated it an antiarrhythmic medication to treat ventricular arrhythmias (life-threatening heart rhythm disturbance where the ventricles [lower chambers of the heart] quiver instead of contracting normally) and atrial fibrillation. The PI also indicated to monitor the patient's cardiac rhythm and blood pressure, and, if bradycardia ensues, a B-adrenergic agonist [a type of medication to increase HR] or a pacemaker may be used . A review of Resident 104's January and February 2025 MARs indicated the nursing staff placed their initials and a check mark on in the entry for the Check BP one time a day with no corresponding BP readings. There were no corresponding BP readings for the administration of furosemide, valsartan or Entresto, and spironolactone. Similarly, there was no documentation of corresponding BP and HR for the administration of metoprolol despite the physician's order to hold for SBP <100 mmHg and HR <60 bpm. Furthermore, there was no hold parameters for or corresponding measurement of BP and HR for the use of amiodarone. Further review of Resident 104's BP and HR summary indicated: - Resident 104's BP was not checked for 14 days from 1/11/25 to 1/26/25; for 3 days from 1/26/25 to 1/30/25; for 7 days from 2/1/25 to 2/8/25; for 2 days from 2/9/25 to 2/12/25; for 5 days from 2/13/25 to 2/18/25; and for 6 days from 2/19/25 to 2/26/25. - Resident 104's HR measurement was not obtained for 14 days from 1/11/25 to 1/26/25; for 4 days from 1/26/25 to 1/30/25; for 11 days from 2/1/25 to 2/13/25, and for 8 days from 2/19/25 to 2/27/25. (continued on next page)

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Santa Cruz Post Acute	1115 Capitola Road Santa Cruz, CA 95062

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review with the Director of Nursing (DON), the Infection Control Preventionist (IP), and Nurse Supervisor D (NS D), on 2/27/25 at 1:45 p.m., they reviewed Resident 104's clinical record and acknowledged the resident's BP and HR were not checked on a daily basis as per physician's order, and before administration of metoprolol; no BP checks done before the administration of Entresto, spironolactone, and furosemide; no hold parameters; and no BP and HR check for amiodarone . The IP and NS D stated the BP and HR should be checked at least daily. The DON, the IP, and NS D also verified there were gaps of multiple days (as stated above) where BP and HR were not checked daily and acknowledged the potential for resident to suffer from undetected severe hypotension and arrhythmias (such as too slow HR). They also verified there was no care plan developed to address the resident's heart failure and amiodarone use. During a telephone interview with the CP on 2/27/25 at 3:30 p.m., he stated residents receiving amiodarone should receive routine HR monitoring, and Resident 104 receiving four antihypertensive medications had a risk of hypotension. When asked whether he had identified and made a recommendation for the nursing staff to include HR and BP monitoring for the use of his antihypertensive and antiarrhythmic medications for Resident 104, the CP stated he did not and confirmed he should have. 4. A review of the PI for digoxin, dated 2015, indicated Digoxin has a narrow therapeutic index [medication in which the therapeutic dose is very close to the toxic dose], increased monitoring of serum digoxin concentrations and for potential signs and symptoms of clinical toxicity is necessary when initiating, adjusting, or discontinuing drugs that may interact with digoxin . Monitor for signs and symptoms of digoxin toxicity and clinical response. Adjust dose based on toxicity, efficacy, and blood levels. A. On 2/28/25 starting at 2:32 p.m., a review of Resident 38's clinical record with Minimum Data Set Coordinator B (MDSC B) indicated the resident had a physician's order for Digoxin Tablet 250 MCG [micrograms, unit of measurement], Give 1 tablet by mouth one time a day for heart failure. dated 1/5/25. MDSC B reviewed Resident 38's list of care plans and confirmed there was no comprehensive care plan developed for the resident's heart failure or digoxin use. MDSC B stated it should have been care planned. B. On 2/28/25 at 2:40 p.m., a review of Resident 111's clinical record with MDSC B indicated she had a physician's order for Digoxin Oral Tablet 125 MCG . Give 1 tablet by mouth one time a day for Antiarrhythmic, dated 6/28/24. MDSC B reviewed Resident 111's clinical record and stated there had been no digoxin level since admission and ordered date of 6/28/24 (a period of 8 months) and had no care plan for the use of digoxin. C. On 2/28/25 at 2:42 p.m., a concurrent interview and record review of Resident 287's clinical record with MDSC B indicated a physician's order for Digoxin Tablet 125 MCG Give 1 tablet by mouth one time a day for heart failure, dated 2/14/2025. MDSC B reviewed the resident's list of care plans and stated she could not find any care plan for the resident's heart failure or digoxin use. She confirmed there should have been a care plan developed. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. On 2/28/25 at 2:44 p.m., a review of Resident 10's clinical record indicated he had been receiving Digoxin Tablet 125 MCG Give 1 tablet by mouth one time a day for heart failure Hold dose if AP less than 60, since 4/24/2021. He also had a physician's order, dated 4/1/24, for laboratory blood tests including the digoxin level every 3 months, scheduled January, April, July, and October each year. MDSC B reviewed Resident 10's clinical record and the contracted laboratory website, and stated she could only found one laboratory report conducted on 4/1/24. She confirmed there was no digoxin level done in July 2024, October 2024, or in January 2025. Also, MDSC B stated she could not find any care plan for the use of digoxin. She acknowledged the physician's order was not carried out and there should be a care plan for the resident's heart failure. E. On 2/28/25 at 3:40 p.m., a review of Resident 54's clinical record with MDSC B indicated a physician's order for Digoxin tablet 125 MCG Give 1 tablet by mouth one time a day for AFib [atrial fibrillation] dated 9/6/2023. MDSC B stated she could not find the comprehensive care plan for AF or digoxin use. She confirmed there should have been a care plan developed. F. On 2/28/25 at 3:57 p.m., a concurrent interview and record review of Resident 121's clinical record with MDSC B indicated a physician's order for digoxin 125 mcg 1 tablet one time a day for AF, dated 10/18/24. MDSC B reviewed the resident's list of care plans and stated there was no care plan for Resident 121's AF or digoxin use. During a telephone interview with the CP on 2/28/25 at 4:12 p.m., he stated digoxin level should be monitored routinely, and he would make a recommendation for it every 6 months. When asked whether he had made a recommendation to draw a digoxin level for Resident 111 since she was admitted in June 2024, the CP stated he did not, and confirmed he should have. Regarding the review for the care plans related to medication use in the residents' clinical record, the CP stated, Sometimes I do but not too much. After reviewing his own record, the CP stated he did not make recommendations on care plans during the monthly MRR for Residents 10, 38, 54, 104, 111, 121, and 287. A review of the facility's P&P titled Pharmacy Services - Role of the Consultant Pharmacist, revised 4/2019, indicated, The consultant pharmacist shall provide consultation on all aspects of pharmacy services in the facility and collaborate with the facility and medical director to: a. Develop, implement, evaluate, and revise (as necessary) the procedures to support resident quality of life such as safe, individualized medication administration programs . The Consultant Pharmacist will provide .Appropriate communication of information to prescribers and facility leadership about potential or actual problems related to any aspect of medications and pharmacy services, including medication irregularities, and pertinent resident-specific documentation in the medical record, as indicated. A review of the facility's P&P titled Medication Regimen Review, dated 5/2019, indicated the CP reviews the MRR for each resident at least monthly, and The MRR involves a thorough review of the resident's medical record to prevent, identify, report and resolve medication-related problems, medication errors and other irregularities . The medication regimen and associated treatment goals involve collaboration with the resident, family members, and the interdisciplinary team (IDT). As such, the MRR includes review of the resident's . stated preferences, the comprehensive care plans and information provided about the risks and benefits of the medication regimen.

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27000 Based on observation, interview, and record review, the facility failed to ensure 13 out of 40 sampled residents (Residents 10, 19, 38, 39, 47, 53, 60, 67, 72, 93, 104, 111, and 121) were free from unnecessary medications when there was inadequate monitoring and systemic failure in the management of antihypertensive (medication to manage high blood pressure) and antiarrhythmic (medication to manage arrhythmia [abnormal or irregular heartbeats]) medications, and lack of monitoring for signs and symptoms related to the use of anticoagulants (medication to prevent blood clots). They are as follows: 1. During a medication pass observation, Licensed Vocational Nurse C (LVN C) failed to measure Resident 47's blood pressure (BP) before administering an antihypertensive medication, losartan 50 milligrams (mg, unit of measurement), to Resident 47. 2a. For Resident 104: - Nursing staff did not carry out the physician's order for daily BP monitoring. - He had a routine order for metoprolol (medication to lower BP and heart rate [HR]) with the direction to hold the medication if SBP less than (<)100 milliliters of mercury (mmHg, unit of measurement) and HR <60 beats per minute (bpm) order but the staff did not check the BP and HR daily before its administration. (Normal HR: 60 - 100 bpm) - He received daily amiodarone (a potent antiarrhythmic agent - medication to treat/prevent irregular or abnormal heart rhythms) without consistent and daily BP and HR monitoring, and without a comprehensive care plan. - He received four routine antihypertensive medications without daily BP monitoring: Metoprolol, Entresto (a combination medication for hypertension and heart failure [a condition when the heart cannot pump enough blood to meet the body's needs]), furosemide (a diuretic, or water pill, to remove excess salt and water, and thereby lowering BP), and spironolactone (a diuretic to manage hypertension). The nursing staff did not code the Medication Administration Record (MAR, official document where staff record medication administration and related monitoring) correctly to require the input of the required BP and HR before administration of these medications. The record review indicated there was a period where BP and HR were not checked for as long as 14 days, as follows: - Resident 104's BP was not checked for 14 days from 1/11/25 to 1/26/25; for 3 days from 1/26/25 to 1/30/25; for 7 days from 2/1/25 to 2/8/25; for 2 days from 2/9/25 to 2/12/25; for 5 days from 2/13/25 to 2/18/25; and for 6 days from 2/19/25 to 2/26/25. - Resident 104's HR measurement was not obtained for 14 days from 1/11/25 to 1/26/25; for 4 days from 1/26/25 to 1/30/25; for 11 days from 2/1/25 to 2/13/25, and for 8 days from 2/19/25 to 2/27/25. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2b. For six residents (Residents 10, 38, 54, 111, 121, and 287) receiving digoxin (an antiarrhythmic agent to treat heart failure and AF) - Resident 38 received digoxin 6 times when HR was outside of the prescribed parameter in January and February 2025 - Resident 111 had no HR obtained on 2/26/24, but digoxin was given - Resident 111 received digoxin daily since admission in June 2024 without monitoring for digoxin blood level (to monitor if the medication is within therapeutic range and to avoid toxicity) - Resident 10 had a physician's order to obtain digoxin level every 3 months since 4/1/24. There was no digoxin level done in July 2024, October 2024, and January 2025. - Six out of six residents did not have comprehensive care plan developed related to digoxin use (see F 656). 2c. The facility's consultant pharmacist (CP) failed to identify and report to the facility irregularities related to the above findings for above residents (Residents 10, 38, 54, 104, 111, 121, and 287) (See F 756) 2d. For eight residents (Residents 19, 38, 60, 67, 72, 93, 104, and 121) receiving amiodarone: - Eight out of eight residents had no documentation of BBW monitoring related to amiodarone - Eight out of eight residents had no documentation of BP and HR checks prior to administration of amiodarone until 2/28/2025 (day of survey); - Resident 72 received amiodarone on 2/28/2025 at 9:00 a.m. with BP of 95/87 when it was supposed to be held and the physician to be notified. - Seven out of eight residents did not have comprehensive care plan developed related to amiodarone use (see F 656). 2e. The competency checks for five licensed nurses (LNs) revealed one out of five LNs did not have nursing care competency and medication administration training (see F 726). The facility's noncompliance related to lack of monitoring of BP and HR prior to antihypertensive and antiarrhythmic medication administration and as ordered; hold parameters not being followed; lack of laboratory monitoring for digoxin level; lack of BBW monitoring for amiodarone; lack of hold parameters for these medications; inaccurate coding of the MAR; lack of comprehensive care planning; and lack of CP's recommendations or identification of irregularities related to these deficient practices had the potential for the residents to suffer adverse effects from severe hypotension or low BP (such as dizziness or lightheadedness, weakness, fatigue, confusion, blurred vision, nausea and vomiting) and worsening arrhythmias (such as chest pain, fainting, rapid or pounding heartbeats, sweating, collapse, and sudden cardiac arrest [heart stop beating suddenly]). Resident 104 had low BP readings on 1/7/25, 1/30/25, 2/1/25, 2/8/25, 2/13/25, and 2/19/25. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Due to these systemic failures (as stated above) with the potential to affect all residents receiving antihypertensive and antiarrhythmic medications, the facility needed to take immediate action to correct the noncompliance. On 2/28/25 at 5:45 p.m., an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified and declared, in the presence of the facility's Administrator, the Director of Nursing (DON), and the Regional Director of Clinical Services (RDCS) related to lack of BP and HR monitoring prior to antihypertensive and antiarrhythmic medication administration and as ordered; lack of laboratory monitoring for digoxin; lack of BP, HR, and BBW monitoring for amiodarone; lack of hold parameters for these medications; lack of comprehensive care planning; and lack of CP's recommendations or identification of irregularities related to these medication use. On 3/3/25, at 1:48 p.m., the IJ was removed after the Administrator submitted an acceptable IJ Removal Plan ([IJRP], a plan with interventions to immediately correct the deficient practices, and after the survey team verified and confirmed the corrective actions while onsite. The acceptable IJRP included the following corrective actions: A. The facility identified residents whose BP and HR need to be monitored. All 59 residents with antihypertensive and antiarrhythmic medications have their updated orders for BP and/or HR check prior to administration, hold parameters, BBW monitoring, digoxin level (when applicable), and developed comprehensive care plan. B. The DON or RDCS in-serviced/trained 7 out of 8 clinical leadership members, and 34 out of 38 licensed nurses (LNs) on ensuring that residents with anti-hypertensive and antiarrhythmic medications have orders for BP and/or HR check prior to administration, hold parameters, BBW monitoring order, digoxin level (when applicable) is carried out, and care plan is developed for use of those medications. LNs who are on vacation or leave and any new registry licensed nurses will be provided in-service/competency training before they work on the floor. C. The CP was provided an in-service by his supervisor on reviewing and identifying medication irregularities during monthly medication regimen review on 3/1/2025. The CP performed an audit of all residents on anti-hypertensive and antiarrhythmic medications for any inconsistencies on BP and/or HR checks prior to medication administration and on applicable lab test recommendations for those medications. This audit was completed by 3/2/2025. D. The interdisciplinary team (IDT, team composed of members from different departments involved in a resident's care) will continue to conduct a daily review of new admissions orders and any new orders for anti-hypertensive and antiarrhythmic medications and verify that those required components are present and being followed. E. The clinical leadership team started with random observation of several LNs during medication pass on 3/1/2025 to ensure that BP and/or HR are checked prior to giving medication(s) and hold parameters are followed. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	F. The Medical Director ([NAME]) has been actively consulted and involved by the clinical leadership team on ensuring that all residents receiving medications have appropriate vital signs (measure of basic functions: body temperature, HR, respiratory rate, BP) monitoring and checks, have hold parameters, and applicable lab orders for use of medications. G. The Medical Records Director (MRD) or designee will continue to perform compliance audits to ensure that residents with anti-hypertensive and antiarrhythmic medications have orders for BP and/or HR check prior to administration, hold parameters, black box monitoring, digoxin level (when applicable), and care plan. H. Corrective Action Plan will be reviewed at QAPI [Quality Assessment and Performance Improvement] Committee Meeting for 6 months using pertinent compliance audit information and resolutions from March 2025 through the end of August 2025 or until the desired outcome of 100% compliance is achieved and sustained for at least six consecutive months. 3. Resident 47 received daily losartan with a hold parameter without the nursing staff monitoring the BP prior to its administration. 4. Resident 104 received amiodarone on 2/28/2025 at 9:00 a.m. with BP of 98/66 when it was supposed to be held and the physician to be notified, after the concerns had been raised with facility leadership staff. 5. Resident 39 received Xarelto (an anticoagulant to prevent blood clots) without evidence of staff monitoring for signs and symptoms related to its use. 6. For Resident 53, the nursing staff did not consistently monitor the signs and symptoms related to the use of Eliquis (an anticoagulant). The failures had the potential for residents to suffer adverse effects of the medications including undetected severe hypotension, worsening of arrythmias, and anticoagulant-related symptoms such as bleeding, bruising, discolored urine, black, tarry stools, lethargy, sudden changes in mental status or vital signs, shortness of breath, or nosebleeds, and untimely interventions for the residents. Findings: The BP is measured in millimeters of mercury (mmHg, unit of measurement) and in two numbers. The upper number is the systolic BP, or SBP, indicating the pressure in the arteries when the heart beats and pumps blood through the body; the lower number is the diastolic BP, or DBP, is the pressure in the arteries when the heart rests between beats. According to the American Heart Association, normal BP is less than 120/80 mmHg; and low BP is a reading lower than 90/60 mmHg (www.heart.org; accessed 3/6/25) 1. During a medication pass observation on 2/24/25 at 9:33 a.m., LVN C was observed preparing and administering 8 medications, including a tablet of losartan 50 mg, to Resident 47. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During the concurrent interview and record review on 2/24/25 at 9:52 a.m., when asked about Resident 47's BP for the administration of losartan, LVN C stated a certified nursing assistant (CNA) had already taken it earlier that day. She reviewed Resident 47's BP in the clinical record which indicated the latest BP was obtained the day prior, on 2/23/25 at 16:08 (4:08 p.m.). LVN C stated she did not check the resident's BP earlier that morning. On 2/24/25 at 9:54 a.m., she was observed returning to Resident 47's bedside and obtained her BP. It was 156/70 mmHg. After returning to the medication cart, LVN C stated, It was a mistake and she should have checked the BP before giving the losartan. A review of Resident 47's clinical record indicated a physician's order, dated 5/21/24, for losartan 50 mg, give 1 tablet one time a day for hypertension hold for systolic [BP] <110 [mmHg]. 2a. A review of Resident 104's admission record indicated he was admitted to the facility with diagnoses including pleural effusion (condition where excess fluid accumulates in the pleural space, the thin cavity between the lungs and the chest wall), heart failure, pulmonary edema (condition where excess fluid accumulates in the lungs, causing difficulty breathing), and unspecified peripheral vascular disease (slow and progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel). A review of the cardiologist's (physician specialized in heart medical conditions) After Visit Summary, dated 9/9/24, indicated the resident was assessed with bruit (abnormal sound in an artery caused by turbulent blood flow). A review of Resident 104's Minimum Data Set (MDS, a care area assessment and screening tool), dated 12/17/24, indicated he had a BIMS (Brief Interview for Mental Status, a test given by medical professionals that helps determine a patient's cognitive understanding, scored from 1 to 15) score of 11, which indicated his cognitive condition was moderately impaired. On 2/27/25, a review of Resident 104's physician's orders, and January and February 2025 Medication Administration Records (MARs), indicated the following orders and administration times: A. Four routine antihypertensive medications: - Valsartan (treat high blood pressure and heart failure) 40 mg 1 tablet twice daily for hypertension, dated 4/12/24. On 1/30/25, valsartan was discontinued and switched to Entresto (combination of valsartan and sacubitril, another antihypertensive medication) 24-26 mg twice daily. One 2/4/25, Entresto was reduced to one time a day for hypertension. Part of its order indicated to Check BP without specified frequency. Each of these medications was scheduled to be administered daily at 10 a.m. - Furosemide 20 mg, give 1.5 tablets (30 mg) one time a day for edema (swelling caused by a buildup of fluid in body tissues) and hypertension, dated 8/23/24. It was scheduled to be administered daily at 9 a.m. - Spironolactone 25 mg, give 1 tablet one time day for fluid retention, dated 12/26/24. It was scheduled to be administered daily at 9 a.m. - Metoprolol extended release (ER) 25 mg one time a day for hypertension, hold for systolic BP < [less than] 100 [mmHg], [HR] <60 [bpm], dated 4/12/24. It was scheduled to be administered daily at 10 a.m. (Normal HR is between 60 - 100 bpm). (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	B. Amiodarone 200 mg, 1 tablet by mouth one time a day for arrhythmia, dated 4/12/24. It was scheduled to be administered daily at 10 a.m. C. Check BP Q [every] day one time a day 'call clinic if SBP is less than 100 [mmHg] consistently, dated 1/30/25. It was scheduled daily at 9 a.m. A review of the Package Insert (PI, document included in the package of a medication that provides information about that drug and its use) for amiodarone, revised 10/2018, indicated it an antiarrhythmic medication to treat ventricular arrhythmias (life-threatening heart rhythm disturbance where the ventricles [lower chambers of the heart] quiver instead of contracting normally) and atrial fibrillation (an irregular heart rhythm that begins in your heart's upper chambers [atria]). The PI also indicated to monitor the patient's cardiac [heart] rhythm and blood pressure, and, if bradycardia [low HR] ensues, a B-adrenergic agonist [a type of medication to increase HR] or a pacemaker may be used . The review of the PI for amiodarone also indicates it has a Black Box Warning (BBW, strongest warning put in the labeling of a prescription drug by the Food and Drug Administration [FDA] to indicate the drug carries a significant risk of serious or life-threatening adverse effects) indicating it has potential to cause life-threatening liver toxicity, pulmonary [lung] toxicity, and worsening arrhythmia. (https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm, accessed 2/28/25) A review of Resident 104's January and February 2025 MARs indicated the nursing staff placed their initials and a check mark on in the entry for the Check BP one time a day with no corresponding BP readings. There were no corresponding BP readings for the administration of furosemide, valsartan or Entresto, and spironolactone. Similarly, there was no documentation of corresponding BP and HR for the administration of metoprolol despite the physician's order to hold for SBP <100 mmHg and HR <60 bpm. Furthermore, there was no hold parameters for or corresponding measurement of BP and HR for the use of amiodarone. Further review of Resident 104's BP and HR summary indicated: - Resident 104's BP was not checked for 14 days from 1/11/25 to 1/26/25; for 3 days from 1/26/25 to 1/30/25; for 7 days from 2/1/25 to 2/8/25; for 2 days from 2/9/25 to 2/12/25; for 5 days from 2/13/25 to 2/18/25; and for 6 days from 2/19/25 to 2/26/25. - Resident 104's HR measurement was not obtained for 14 days from 1/11/25 to 1/26/25; for 4 days from 1/26/25 to 1/30/25; for 11 days from 2/1/25 to 2/13/25, and for 8 days from 2/19/25 to 2/27/25. A review of Resident 104's clinical record also indicated there was no comprehensive care plan that included the diagnosis, goals/outcomes, monitoring parameters and interventions for Resident 104's arrhythmia or the monitoring of the BBW related to amiodarone use. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a concurrent interview and record review with the Director of Nursing (DON), the Infection Control Preventionist (IP), and Nurse Supervisor D (NS D) on 2/27/25 at 1:45 p.m., they reviewed Resident 104's clinical record and acknowledged the resident's BP and HR were not checked on a daily basis as per physician's order, and before administration of metoprolol; no BP checks done before the administration of Entresto, spironolactone, and furosemide; no hold parameters and no BP and HR check for amiodarone; and no comprehensive care plan for Residentn104's arrhythmia and amiodarone use. The IP and NS D stated the BP and HR should be checked at least daily, and the care plan should have been developed. The staff present also verified there were gaps of multiple days (as stated above) where BP and HR were not checked daily and acknowledged the potential for resident to suffer from undetected severe hypotension and arrhythmias (such as too slow HR) During an interview with Resident 104 on 2/27/25 at 2:09 p.m., when asked how often the staff obtained his HR, he stated, Here and there. About the BP measurement, Resident 104 stated, They get it when they come in, sometimes 2 to 3 times per day. It depends. During a telephone interview with the CP on 2/27/25 at 3:30 p.m., he stated residents receiving amiodarone should receive routine HR monitoring, and Resident 104 receiving four antihypertensive medications had a risk of hypotension. When asked whether he had identified and made a recommendation for the nursing staff to include HR and BP monitoring for the use of his antihypertensive and antiarrhythmic medications for Resident 104, the CP stated he did not. During an interview with the DON on 2/27/25 at 4:33 p.m., she stated, The blood pressure and pulse were not consistently done . The MAR was not coded right so it's not on the MAR. She explained the MAR should be coded to require an input of the BP and/or HR with BP and cardiac (heart) medications. When asked whether the BP and HR measurements were documented somewhere else, the DON stated no and that she checked the CNA's logs, and it's not there. On 2/28/25 at 9:26 a.m. in the presence of the Assistant Director of Staff Development (ADSD), a review of Resident 104's February 2025 MAR was conducted with LVN G. She confirmed she administered the metoprolol with the prescribed hold parameters, and documented she checked the BP on 2/5 and 2/6/25; however, there was no BP and HR measurement in the clinical record for both days. Both LVN G and the ADSD stated the nursing staff check BP and HR before giving BP and cardiac medications. The ADSD also reviewed the clinical record and stated, I am not sure what to say. During a concurrent interview and record review with LVN H on 2/28/25 at 9:42 a.m., she reviewed Resident 104's February 2025 MAR and confirmed she documented the administration of metoprolol with ordered hold parameters, and did the daily BP on 2/25/26; however, there were no BP and HR measurement on 2/25/26 in Resident 104's clinical record. She stated, If the MAR doesn't say then I don't put in there unless I put in the progress notes. When asked to look up the progress notes, LVN H stated, I know I did not. During a concurrent interview and record review with LVN I on 2/28/25 at 9:55 a.m., a review of Resident 104's February 2025 MAR with LVN I indicated she documented she administered the metoprolol and did the daily BP check on 2/10, 2/11, 2/15, and 2/21/25 during which there were no documentation of daily BP and HR measurement. She stated, I checked them but not entered into the system because it didn't have entry to enter, but I always check them. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a concurrent interview and record review with Registered Nurse (RN) J on 2/28/25 at 10:11 a.m., a review of Resident 104's February 2025 MAR with RN J indicated she administered the BP medications, including the metoprolol; and the daily BP check, on 2/3, 2/4, 2/14, 2/22, 2/23, and 2/26/25 during which there were no BP and HR measurement in the clinical record. RN J acknowledged there were BP and HR missing in the MAR and stated, I understand what you are saying. There's no excuse for it. She also acknowledged Resident 104 was receiving four BP medications which had the potential for severe hypotension if not checked. She stated the nurses can change the order when the MAR did not have entries to input BP and HR, but acknowledged they were not done prior to being brought up by the survey team (on 2/27/25). A request was made for an interview with Resident 104's physician (Physician A) on 2/28/25. During an interview on 2/28/25 at 10:55 a.m., Nursing Supervisor D (NS D) stated she just received a telephone call from Physician A who said she is not available for interview as she was in a conference. NS D stated Physician A wanted her to relay the message to the surveyor that Resident 104 was being followed by the cardiologist. NS D also stated that Physician A said she has had concerns about the care in the facility and that is the reason why she would not admit new patients to this facility until things are fixed. On 2/28/25 at 11:35 a.m., a telephone interview was conducted with the Medical Director ([NAME]). When asked about the expectation of staff obtaining and documenting the BP and HR for antihypertensive and cardiac medications, he stated, If there's a standing order, it should be documented. Ideally. During a concurrent interview and record review with NS D on 2/28/25 at 11:47 a.m., a review of Resident 104's BP summary in the electronic record indicated he had low BP readings (see below). NS D stated she could not tell if the BP readings were before or after metoprolol administration on 2/1, 2/8, and 2/13/25. She was asked to provide the exact timing of the metoprolol administration for those days. Date and time BP readings in mmHg - 1/7/25 at 1:40 a.m. 108/58 - 1/30/25 at 10:23 a.m. 101/50 - 2/1/25 at 10:20 a.m. 93/54 - 2/8/25 at 9:10 a.m. 91/56 - 2/13/25 at 8:52 a.m. 96/54 - 2/19/25 at 1:02 a.m. 95/54 During a follow-up interview with NS D on 3/1/25 at 4:07 p.m., she stated the electronic system only allowed a 14-day look back of medication administration times, so she could not provide the exact time the metoprolol was administered on those days. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of an online article from the National Heart, Lung, and Blood Institute titled Low Blood Pressure, updated 3/14/22, indicated hypotension symptoms included: Confusion, dizziness or lightheadedness, fainting, feeling tired or weak, blurry vision, headache, neck or back pain, nausea, and heart palpitations. (https://www.nhlbi.nih.gov/health/low-blood-pressure, accessed 2/28/25) A review of the online publication titled Symptoms, Diagnosis and Monitoring of Arrhythmia dated 10/10/24, by the American Heart Association (www.heart.org), severe arrhythmia symptoms include: Fatigue or weakness, dizziness or lightheadedness, fainting or near-fainting spells, shortness of breath, chest pain, alternating fast and slow heart rate, sweating, and in extreme cases, collapse and sudden cardiac arrest. 2b. A review of the PI for digoxin, dated 2015, indicated Digoxin has a narrow therapeutic index [medication in which the therapeutic dose is very close to the toxic dose], increased monitoring of serum digoxin concentrations and for potential signs and symptoms of clinical toxicity is necessary when initiating, adjusting, or discontinuing drugs that may interact with digoxin . Monitor for signs and symptoms of digoxin toxicity and clinical response. Adjust dose based on toxicity, efficacy, and blood levels. On 2/28/25 starting at 2:30 p.m., a concurrent interview and review of the clinical records residents receiving digoxin was conducted with Minimum Data Set Coordinator B (MDSC) B. The following was identified: A. On 2/28/25 starting at 2:32 p.m., a review of Resident 38's clinical record with MDSC B indicated the resident had a physician's order for Digoxin Tablet 250 MCG [micrograms, unit of measurement], Give 1 tablet by mouth one time a day for heart failure check apical heart rate [or apical pulse or AP; heartbeat that is felt or heard at the apex (bottom) of the heart, typically on the left side of the chest] prior to each dose. Hold dose if heart rate is less than 60 and notify MD [medical doctor], dated 1/5/25. A review of Resident 38's January and February 2025 MARs indicated the nursing staff did not hold the resident's digoxin when he had the documented pulse (HR) of less than 60 bpm on: 1/20 (HR: 58); 1/26 (HR: 53); on 2/3 (HR: 59), on 2/5 (HR: 53), 2/7 (HR: 55), and 2/18/25 (HR: 59). MDSC B also reviewed the progress notes and stated there was no physician's notification on those days. She confirmed the physician's order was not followed. Furthermore, there was no comprehensive care plan developed for the resident's heart failure or digoxin use. MDSC B stated it should have been care planned. B. On 2/28/25 at 2:40 p.m., a review of Resident 111's clinical record with MDSC B indicated Resident 111 had a physician's order for Digoxin Oral Tablet 125 MCG . Give 1 tablet by mouth one time a day for Antiarrhythmic Hold if APICAL pulse <60 [bpm], dated 6/28/24. A review of Resident 111's February 2025 MAR indicated digoxin was documented as administered to the resident on 2/26/25, but there was no documented AP on that day. MDSC B verified this finding. She also confirmed there was no care plan developed for the use of digoxin, and stated there should have been a care plan developed. Also, the review of Resident 111's clinical record with MDSC B indicated no digoxin level since admission and ordered date of 6/28/24 (a period of 8 months). (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	C. On 2/28/25 at 2:42 p.m., a concurrent interview and record review of Resident 287's clinical record with MDSC B indicated a physician's order for Digoxin Tablet 125 MCG Give 1 tablet by mouth one time a day for heart failure hold if pulse less than 70, dated 2/14/2025. MDSC B stated she could not find any care plan for the resident's heart failure or digoxin use. She confirmed there should have been a care plan developed. D. On 2/28/25 at 2:44 p.m., a review of Resident 10's clinical record indicated he had been receiving Digoxin Tablet 125 MCG Give 1 tablet by mouth one time a day for heart failure Hold dose if AP less than 60, since 4/24/2021. He also had a physician's order, dated 4/1/24, for laboratory blood tests including the digoxin level every 3 months, scheduled January, April, July, and October each year. MDSC B reviewed Resident 10's clinical record and the contracted laboratory website and stated she could only found one laboratory report conducted on 4/1/24. She confirmed there was no digoxin level done in July 2024, October 2024, or in January 2025. Also, MDSC B stated she could not find any care plan for the use of digoxin. She acknowledged the physician's order was not carried out and there should be a care plan for the resident's heart failure. E. On 2/28/25 at 3:40 p.m., a review of Resident 54's clinical record with MDSC B indicated a physician's order for Digoxin tablet 125 MCG Give 1 tablet by mouth one time a day for AFib [atrial fibrillation] hold if less than 60 [bpm] and notify M.D as needed, dated 9/6/2023. MDSC B stated she could not find the comprehensive care plan for AF or digoxin use. She confirmed there should have been a care plan developed. F. On 2/28/25 at 3:57 p.m., a concurrent interview and record review of Resident 121's clinical record with MDSC B indicated a physician's order for digoxin 125 mcg 1 tablet one time a day for AF, dated 10/18/24. MDSC B stated there was no care plan for Resident 121's AF or digoxin use. 2c. During a telephone interview with the CP on 2/28/25 at 4:12 p.m., the CP stated digoxin level should be monitored routinely, and he would make a recommendation for it every 6 months. When asked whether he had made a recommendation to draw a digoxin level for Resident 111 since she was admitted in June 2024, the CP stated he did not, and confirmed he should have. Regarding the review for the care plans related to medication use in the residents' clinical record, the CP stated, Sometimes I do but not too much. After reviewing his own record, the CP stated he did not make recommendation on care plans during the monthly medication regimen review for Residents 10, 38, 54, 111, 121, and 287. 44583 2d. A concurrent interview and record review of seven additional residents (Residents 19, 38, 60, 67, 72, 93, and 121) receiving amiodarone indicated: A. Review of Resident 121's clinical record titled, Admission Record, dated 2/28/25, indicated Resident 121 was admitted to the facility with diagnoses including hypertensive heart and chronic kidney disease (refers to a condition where high blood pressure damages both the heart and kidneys) with heart failure and stage 1 through stage 4 chronic kidney disease (occurs when kidneys work harder to filter blood and may stop working altogether), paroxysmal atrial fibrillation (a fast, irregular heartbeat that only lasts a few hours or days), and cardiomyopathy (a disease that affects the heart muscle, making it difficult for the heart to pump blood). (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident 121's physician order, dated 12/20/24, indicated, Amiodarone . 100 MG Give 1 tablet by mouth one time a day for CHF [chronic heart failure, a condition where the heart can't pump enough blood to meet the body's needs]. Amiodarone was scheduled to be given daily at 9:00 a.m. During a concurrent interview with the Assistant Director of Staff Development (ADSD) and record review on 2/28/25 at 3:35 p.m., the ADSD reviewed Resident 121's physician's order and the February 2025 MAR, and confirmed there was no documentation from nursing that the amiodarone's BBW was being monitored. The ADSD further confirmed there was no documented BP and HR readings in the MAR from 2/1 to 2/27/25 prior to administration of amiodarone. ADSD also confirmed there was no care plan developed for Resident 121's amiodarone use. During a follow-up interview with MDSC B on 2/28/25 at 3:58 p.m., MDSC B stated nurses should check and document Resident 121's BP and HR prior to administration of amiodarone. MDSC [TRUNCATED]

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 27000 Based on interview and record review, the facility failed to ensure three out of 28 sampled residents (Residents 45, 104, and 107) were free from unnecessary psychotropic medications (drugs that affects brain activities associated with mental processes and behavior) when: 1. Resident 45 received as-needed (PRN) lorazepam (brand name: Ativan; medication to treat agitation and anxiety) beyond 14 days without the physician-documented clinical rationale and a specified duration for the extended period. 2. Resident 107 received Depakote (a medication to treat mood disorder) and quetiapine (brand name: Seroquel, an anti-psychotic medication) without the facility staff monitoring for their side effects, and without laboratory monitoring for A1c (measures your average blood glucose level over the past 3 months) and lipid panel (a blood test that measures the levels of various fats [lipids] in the bloodstream) related to Seroquel use. 3. Resident 104 received PRN lorazepam exceeding 14 days without the physician-documented clinical rationale and a specified duration for the extended period; received PRN Seroquel beyond 14 days; and received routine Seroquel with inappropriate indication and inaccurate behavior monitoring for its use. The failures resulted in unnecessary psychotropic medications for the residents, which had the potential for increased risks associated with psychotropic medication use that include but not limited to sedation, respiratory depression, falls, constipation, anxiety, agitation, abnormal involuntary movements, and memory loss. Findings: 1. A review of Resident 45's clinical record indicated she was admitted with diagnoses including unspecified anxiety disorder. A review of her physician's orders included the following: a. Lorazepam 0.5 mg, give 1 tablet by mouth at bedtime for anxiety manifested by (m/b) inability to relax, dated 10/23/24 b. Lorazepam 0.5 mg, Give 1 tablet by mouth every 24 hours as needed for anxiety DO NOT DISCONTINUE PRN ORDER, dated 11/22/24 (3 months ago). There is not documented evidence in Resident 45's clinical record indicating the rationale why the resident needed the PRN lorazepam beyond 14 days, nor did the order itself had a specified duration. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and review of Resident 45's clinical record with the Director of Nursing (DON), the Director of Staff Development (DSD), and the Social Service Director (SSD) on 2/27/25 at 10:47 a.m., they all acknowledged PRN lorazepam are limited to 14 days. The SSD stated the order was written by the physician assistant (PA) to do not discontinue. The staff present could not provide any documentation of the rationale for extending the PRN beyond 14 days, and the order itself did not indicate a duration of how long the order was for. 2. A review of Resident 107's clinical record indicated she was admitted to the facility with diagnoses including unspecified dementia (a condition characterized by memory loss). A review of Resident 107's physician orders included the following: a. Depakote 250 mg, 1 tablet by mouth two times a day for mood liability manifested by poor impulse control, dated 2/14/25 b. Quetiapine 12.5 mg by mouth two times a day for dementia m/b by aggressive verbal behaviors, dated 5/11/24 (7 months ago). A review of Resident 107's clinical record indicated there had been no monitoring for the side effects of Depakote since ordered date of 2/14/25; and of quetiapine since 1/9/25. Also, there had been no monitoring for the resident's lipid panel or A1c. A review of the Drug Information (https://dailymed.nlm.nih.gov/dailymed) for quetiapine indicated antipsychotics have been associated with metabolic [related to physical and chemical] changes. These metabolic changes include hyperglycemia [high blood glucose], dyslipidemia [abnormal levels of lipids in the bloodstream]. It indicates to monitor for glucose regularly in patients with diabetes or at risk for diabetes and fasting blood lipid at the beginning of, and periodically, during treatment. During a concurrent interview and record review with Nursing Supervisor D (NS D) on 2/26/25 at 5:13 p.m., she reviewed Resident 107's clinical record and verified the absence of side effect monitoring for Depakote and quetiapine. She stated she does not see why the monitoring for quetiapine was stopped on 1/9/25 (more than a month ago) while the resident continued to receive the medication. Regarding the A1c and lipid panel monitoring, she acknowledged antipsychotic medications could lead to changes in blood glucose and lipids, and stated she would need to look further. During a follow-up interview on 2/27/25 at 10:17 a.m., NS D stated she looked through the entire record for Resident 107 and could not find any A1c or lipid panel blood test results. She also stated she did not see any recommendations from the consultant pharmacist. 3. A review of Resident 104's clinical record indicated he was admitted to the facility with diagnoses including unspecified anxiety disorder and unspecified depression. A review of Resident 104's physician orders included the following: a. Lorazepam 1 mg, 1 tablet by mouth every 24 hours as needed for anxiety, dated 7/5/24 (seven months ago). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Seroquel 25 mg, give 1 tablet at bedtime as needed for insomnia. To be given in addition to 25 mg tab routine if still unable to sleep. Do not discontinue PRN PRN order, dated 9/27/24 (5 months ago). c. Seroquel 50 mg (Quetiapine), Give 1 tablet by mouth at bedtime for depression per [psychiatrist's name], dated 11/1/24 A review of Resident 104's care plan, dated 10/23/24, indicated the resident uses of seroquel as for insomnia due to altered mental status unable to sleep at night. A review of Resident 104's February 2025 MAR indicated the nursing staff monitored for episodes of aggressive behavior for use of Quetiapine every shift . dated 7/23/24. During a concurrent interview and record review with the DON, the Infection Control Preventionist (IP), and Registered Nurse J (RN J) on 2/27/25 at 1:30 p.m., they acknowledged Resident 104's clinical record had no physician-documented rationale why PRN lorazepam order was extended beyond 14 days. The order itself had no specified duration for the extended period. Similarly, the PRN Seroquel was written 5 months ago while the federal regulation indicated a maximum of 14 days. Regarding the routine Seroquel use, the DON verified the indication was for depression while the staff monitored for aggressive behavior, and its care plan was for altered mental status unable to sleep at night. She also acknowledged the indication of altered mental status and insomnia are not appropriate indications for antipsychotic medication use. A review of the facility's policy and procedures (P&P) titled Psychotropic Medication Use, dated 7/2022, indicated, Psychotropic medications are not prescribed or given on a PRN basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. a. PRN orders for psychotropic medications are limited to 14 days. (1) For psychotropic medications that are NOT antipsychotics: If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order. (2) For psychotropic medications that ARE antipsychotics: PRN orders cannot be renewed . A review of the facility's P&P titled Antipsychotic Medication Use, dated 12/2016, indicated: The Attending Physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms ., Antipsychotic medications will not be used if the only symptoms are one or more of the following . insomnia and Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the Attending Physician . Metabolic: increase in total cholesterol/triglycerides, unstable or poorly controlled blood sugar .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 27000 Based on observation, interview, and record review, the facility had a medication error rate of 12.12% when four medication errors were observed out of 33 opportunities during medication administration for three out of six residents (Residents 6, 47, and 296). Resident 296 and Resident 6 received crushed medications when the manufacturer indicated not to crush; senna (a laxative) was missed for Resident 6; and Resident 47 received the wrong dose of vitamin C. This failure resulted in residents not receiving medications as prescribed and/or according to manufacturers' specifications, and had the potential to result in residents not receiving the full therapeutic benefit of their medications or experiencing negative health outcomes. Findings: 1. During a medication administration observation and interview on 2/24/25 at 8:43 a.m., registered nurse F (RN F) was observed preparing 9 medications, including a tablet of metoprolol (medication to to treat high blood pressure or hypertension) extended release (ER, medication is formulated so that the drug is released slowly over time) 25 milligrams (mg, unit of measurement), to give to Resident 296. RN F was observed crushing all the tablets and poured the crushed contents into a medicine cup. RN F stated Resident 296, likes them all crushed together. RN F added a spoonful of yogurt to the crushed powder and spoon-fed the mixture to Resident 296 at his bedside. During an interview on 2/24/25 at 9:02 a.m., RN F stated that metoprolol ER shouldn't be crushed, but it was. During an interview with Resident 296 on 2/25/25 at 9:01 a.m., he stated his medications are crushed, all the time. Resident 296 stated that he does not remember the reason his medications are crushed, but said he likes them crushed. During another interview with RN F on 2/25/25 at 9:08 a.m. RN F stated that Resident 296, always takes his meds crushed. RN F acknowledged metoprolol ER should not be crushed due to being extended released. A review of Resident 296's clinical record indicated a physician's order, dated 1/30/25, for Metoprolol Succinate ER Tablet Extended Release 24 Hour 25 MG Give 1 tablet by mouth one time a day for HTN [hypertension]. During an telephone interview with the Consultant Pharmacist (CP), he stated metoprolol ER should not be crushed due to its formulation. A review of drug resource, DailyMed (https://dailymed.nlm.nih.gov), indicated, Metoprolol succinate extended-release tablets are scored on both sides and can be divided; however, do not crush or chew the whole or half table. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a medication administration observation on 2/24/25 at 9:17 a.m., Licensed Vocational Nurse (LVN) C was observed preparing four medications, a total of 6 pills, for Resident 6. The medications included a tablet of potassium chloride (to treat low potassium level in the blood) ER 20 milliequivalents (mEq, a unit of measure). On 2/24/25 at 9:22 a.m., at Resident 6's bedside, LVN C was observed administering the medications to Resident 6, in whole pills, with applesauce. The resident swallowed the applesauce but not the medications. She pushed the large pills out of her mouth using her tongue. LVN C took the medications from the resident's mouth. On 2/24/25 at 9:26 a.m., LVN C returned to the medication cart and stated the rejected medications were the potassium ER tablet, a Tylenol 500 mg tablet, and docusate sodium (stool softener) 250 mg tablet. She disposed of the medications and retrieved new ones from the medication cart, crushed them into a fine powder, and mixed with applesauce. On 2/24/25 at 9:29 a.m., LVN C returned to Resident 6's bedside and administered the medication-applesauce mixture to the resident. During a concurrent interview with LVN C at 2/24/25 at 10:02 a.m. and a review of the pharmacy label for potassium ER 20 mEQ tablet indicated its manufacturer is Manufacturer A, and a warning label indicating May be Broken or Allowed to Disintegrate In Water (Stir Well) Before Swallowing. Rinse Down With Water, But Do Not Chew, All of The Remaining Particles. LVN C acknowledged it should not be crushed. A review of Manufacturer A's drug information for potassium chloride ER tablet, revised 3/2023, indicated, To take each dose without crushing, chewing or sucking the tablets. A review of Resident 6's clinical record indicated a physician's order, dated 2/23/24, for Potassium Chloride ER Tablet Extended Release 20MEQ Give 1 tablet by mouth one time a day for supplement. During a telephone interview with the CP on 2/27/25 at 11:18 a.m., he stated potassium ER tablet should not be crushed. A review of the facility's policy titled, Crushing Medications, revised April 2018, indicated Medications shall be crushed only when it is appropriate and safe to do so, consistent with physician orders 1. The medical director and director of nursing services, in conjunction with the consultant pharmacist, shall identify appropriate indications and procedures for crushing medications. 3. During a medication administration observation with LVN C for Resident 6 (as above) on 2/24/2025 at 9:17 a.m., there were a total of 4 medications (total of 6 pills). The number of pills was verified with LVN C before she entered Resident 6's room. A review of Resident 6's clinical record indicated a physician's order for Senna Tablet 8.6 MG Give 2 tablet by mouth two times a day for constipation, dated 1/11/2020. It was scheduled daily at 9 a.m. Senna was not observed prepared and given to Resident 6 during the morning medication administration by LVN C on 2/24/25. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review with LVN C on 2/24/25 at 11:50 a.m., she reviewed Resident 6's physician's orders and acknowledged senna was not administered. She stated, I will go give it now. A review of the facility's policy titled, Medication Administration, revised April 2019, indicated Medications are administered within one (1) hour of their prescribed time, unless otherwise specified . 4. During a medication administration observation on 2/24/25 at 9:33 a.m., LVN C was observed preparing and administering 10 medications, including 2 tablets of vitamin C 500 mg (total 1,000 mg), to Resident 47. A review of Resident 47's clinical record indicated a physician's order, dated 5/30/24, for Vitamin C Oral Tablet 500 MG . Give 1 tablet by mouth two times a day for Supplement. On 2/24/25 at 11:45 a.m., during a concurrent interview and review with LVN C, she reviewed Resident 47's vitamin C order, then looked through the medication cart. She showed the surveyors the Vitamin C 500 mg bottle, which she had used earlier for Resident 47. She stated she thought the Vitamin C bottle label read 250 mg, that was the reason why she gave 2 tablets. LVN C confirmed she gave twice the ordered dose. A review of the facility's policy titled, Medication Administration, revised April 2019, indicated, Medications are administered in accordance with prescriber orders .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 27000 Based on observation, interview, record review, the facility failed to ensure medications were properly stored and labeled in three of three medication carts and in two of three medication rooms. Multiple opened inhalers, eye drops, and multi-dose vials were not labeled with open dates, or with an accurate expiration date, or being used past their discard dates. Also, one of three medication refrigerators was identified with incorrect setting and with temperature reading below freezing. These failures had the potential for residents to receive outdated and/or ineffective medications which could result in the residents not receiving the full benefit of the medications and negative health outcomes. Findings: 1. During an inspection of Station 4 Medication Cart on 2/24/25 at 10:57 a.m. with licensed vocational nurse E (LVN E), the following were identified and confirmed with LVN E: a. An eye drop latanoprost (medication to lower pressure in the eye) bottle, for Resident 15, did not have a label indicating when it was opened. LVN E stated it should have an open date. b. Another latanoprost eye drop bottle, for Resident 36, had an open date of 1/4/25. A review of the product labeling for latanoprost, dated 9/27/24, indicated Once a bottle is opened for use, it may be stored at room temperature . for 6 weeks. c. An opened fluticasone/vilanterol inhaler (to treat breathing problems) 100 micrograms (mcg)/25 mcg had an open date of 11/8/2024. The product labeling indicated to discard 6 weeks after opening. LVN E acknowledged that the medication expired. LVN E stated that the resident is no longer taking this medication. LVN E stated that the medication should be removed from the cart. d. An opened Humulin R insulin (medication to lower blood sugar) vial, for Resident 9, had an open date label listed as 1/20/25. The product labeling indicated to discard 31 days after opening. LVN E acknowledged the insulin vial expired. 2. During an inspection of Station 1 Medication Cart on 2/24/25 at 11:29 a.m. with the Minimum Data Set Coordinator B (MDSC B), a bottle of senna (a laxative, a medication to promote bowel movements) syrup was identified with an expiration date of 1/2025. MDSC B verified the medication expired. 3. During an inspection of the Station 2B Medication Cart with Nursing Supervisor D (NS D) on 2/24/25 at 11:54 a.m., the following were identified and confirmed with NS D: a. An insulin lispro (short acting insulin, to lower blood sugar) vial, for Resident 38, did not have an open date label. A review of the product labeling for insulin lispro indicated to discard 28 days after opening. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Three opened insulin lispro vials and one Lantus (long-acting insulin) vial had the manufacturer's expiration date handwritten on the label instead of the 28-day expiration date from the date they were opened. c. An opened latanoprost eye drop bottle for Resident 8 had an open date of 1/8/25. NS D verified it was being used past the 6-week discard date. d. An opened Trelegy inhaler (to treat breathing problems) without an open date. The product labeling on the Trelegy carton indicated, Discard the inhaler 6 weeks after opening . During this inspection, NS D verified the above medications were either mislabeled with an incorrect expiration date, missing a date open label. and/or expired. 4. During a visit to the Station 2 Medication Room with the Assistant Director of Nursing (ADON) on 2/25/25 at 9:20 a.m., an opened tuberculin (used to test for tuberculosis, a lung infection) vial was identified without an open date. The product labeling on the carton indicated to discard the vial 30 days after opening. The ADON verified this finding. A review of the facility's policy and procedures (P&P) titled Medication Storage and Labeling for Single dose/Multi-dose Container, revised April 2019, indicated, 'When opening a multi-dose container, the date opened is recorded on the container. A review of the facility's P&P titled Storage of Medications, revised April 2007, indicated, The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. 5. During a visit to the Automated Dispensing Unit (ADU) Medication Room with the ADON on 2/24/25 at 3:44 p.m., a medication refrigerator was identified in the room. The refrigerator was observed to contain 14 full boxes (each box contained 10 single-dose syringes) and one partial box with four syringes of Fluad (a type of flu vaccine), one full box and three partial boxes of Flucelvax (a type of flu vaccine), and one full box and 1 partial box of 7 syringes of Prevnar (a type of pneumonia vaccine). The display inside the refrigerator read 32 degrees Fahrenheit (F, a unit of measurement for temperature). 32 F is freezing temperature. The ADON stated this was the refrigerator's setting. The thermometer inside the refrigerator had a reading of 28 F (below freezing). During this visit, a review of the product labeling on the Fluad carton with the ADON indicated, Store between 2 - 8 C [Celsius] (36 - 46 F). Do not freeze. Discard if the vaccine has been frozen. A review of the Consumer Medicine Information Summary for Flucelvax, dated 1/2025, indicated, Keep it in the refrigerator, between 2 C and 8 C. Do not freeze Flucelvax(R) Quad. Protect from light. Discard if the vaccine has been frozen. Freezing destroys the vaccine. A review of the product labeling for Prevnar, dated 4/2023, indicated: Store refrigerated at 2 C to 8 C (36 F to 46 F) . Do not freeze. Discard if the vaccine has been frozen. During a follow-up visit to the ADU room with the ADON on 2/25/25 at 9:19 a.m., she stated, I don't know why the refrigerator was originally set to 32 F . We're checking it frequently [since yesterday]. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's P&P titled Medication Storage - Refrigerators and Freezers, revised December 2014, indicated, Acceptable temperature ranges are 35 F to 40 F for refrigerators.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44185 Based on observation, interview and record review, the facility failed to ensure palatability and nutritive value of cooked foods were maintained when: 1. Three of 28 sampled residents complained that the food tasted bland (lacking taste or flavor); 2. Pureed foods (a pureed diet is an eating plan where all the foods have a soft, pudding-like consistency. It is a texture-modified diet that is often recommended for people who can't eat solid foods) were held in the heated oven for an extended time; and, 3. The recipe for making pureed food was not followed. These failures resulted in decreased food palatability that could lead to decrease in food consumed by residents, and the food held in the heated oven for extended time periods could lose nutritive value, leading to a decreased nutrient intake for the thirteen residents on puree diet order out of 139 facility residents. Findings: 1. During the concurrent observation and interview of Resident 16 on 2/23/25 at 11:25 a.m., Resident 16 was in his bed, alert, oriented and verbally responsive. Resident 16 said that his food tasted bland. Review of the admission record (document created when a resident is admitted to a healthcare facility, containing the vital information about the resident) of Resident 16 indicated, Resident 16 was admitted to the facility on [DATE] with the primary diagnosis of unspecified gout (painful form of arthritis causing swelling in the joints). Review of the order summary report of Resident 16 dated 3/1/25 indicated, Resident 16 had an order of no added salt diet, regular texture (foods without any modifications), with thin liquid consistency (liquid that is easy to pour and no additives), ordered and started on 1/6/25. During the concurrent observation and interview of Resident 88 on 2/23/25 at 11:26 a.m., Resident 88 was laying in his bed, calm and verbally responsive. Resident 88 stated that he had issues with his food. They tasted bland. Review of Resident 88's admission record indicated, Resident 88 was admitted to the facility on [DATE] with the primary diagnosis of unspecified Alzheimer's disease (progressive disease that destroys memory and other important mental functions). Review of Resident 88's order summary report dated 3/3/25 indicated, Resident 88 had an order of regular diet, mechanical soft texture (food consistency that is easy to chew and swallow), thin liquids consistency, fortified diet (diet that includes foods that have been enriched with additional vitamins and minerals), ordered and started on 8/19/22. (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 concurrent observation and interview of Resident 15 on 2/23/25 at 11:32 a.m., Resident 15 was in his bed, calm, alert and verbally responsive. Resident 15 stated that the food did not taste good and tasted bland. Review of Resident 15's admission record indicated, Resident 15 was admitted to the facility on [DATE] with the primary diagnosis of cerebral ischemia (common mechanism of acute brain injury that results from impaired blood flow to the brain). Review of Resident 15's order summary report dated 3/3/25 indicated, Resident 15 had an order of regular diet, pureed texture (smooth, uniform texture that's soft and semi-liquid, without stringy bits), thin liquids consistency, ordered and started on 11/13/24. During the test tray observation and tasting with cook M (COOK M) and the dietary manager (DM) on 2/26/25 at 2:10 p.m., two test trays were brought and tasted. One of the test trays contained regular ground beef, rice and vegetables. The second tray contained pureed beef, rice and green beans. The pureed rice and pureed green beans tasted bland. The regular ground beef and regular rice also tasted bland. During the concurrent interviews with COOK M and the DM after they tasted the two test trays, on 2/26/25 at 2:13 p.m., COOK M and DM verified that the pureed rice, pureed green beans, regular ground beef and regular rice, all tasted bland and will check on them. 2. During the concurrent pureed making observation and interview with COOK M on 2/26/25 at 11:29 a.m., COOK M stated that she was already done in making the pureed rice and pureed vegetables at 10:30 a.m., and they were placed in the oven, heated at 300 degrees Fahrenheit (temperature scale). During an interview with COOK M on 2/26/25 at 2:37 p.m., COOK M verified that the pureed rice and pureed vegetables were prepared ahead of time, more than 1 hour from the tray line preparation. It was prepared at 10:30 a.m., and the tray line preparation (a system of food preparation used in healthcare facilities) started at 11:40 a.m., and acknowledged that she would not do it next time. During an interview with the DM on 2/26/25 at 2:40 p.m., the DM verified that the pureed rice and pureed vegetables were prepared more than 1 hour from the tray line preparation and will remind COOK M, not do it next time. During an interview with the registered dietitian (RD), on 2/28/25 at 8:54 a.m., the RD verified that COOK M should not prepare the pureed rice and pureed vegetables more than 1 hour from the tray line preparation and then placed them in the oven, heated at 300 degrees Fahrenheit, to preserve their nutritive value and taste. During an interview with the director of nursing (DON), on 2/28/25 at 5:35 p.m., the DON acknowledged the finding and would follow up on it. Review of the facility's policy titled, HACCP (Hazard Analysis and Critical Control Point) - Tips for Safety, dated 2008 indicated, Avoid holding foods for long periods of time (serve and consume within 1 hour of preparation) (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During the concurrent meat pureed making observation and interview with COOK M, on 2/26/25 at 11:30 a.m., COOK M was making ground beef pureed. COOK M acknowledged that she did not know the amount of ground beef that was placed in the container for pureed preparation. COOK M, then got a scoop, not using the #6 scoop (scoop used for ground beef pureed making), to measure the amount of ground beef to be pureed. COOK M placed 14 scoops of ground beef in the robot coupe machine, then pureed it. Added 1 cup of water and then another cup of water to the pureed ground beef. Review of the facility's undated production recipe titled, Pureed Tacos Beef Soft indicated, Using #6 scoop, for 2 beef soft tacos per resident on pureed diet, measure desired number of servings into food processor. Blend until smooth. Add broth or gravy if product needs thinning. Add commercial thickener if product needs thickening There was no mention to add water into the pureed ground beef. During the concurrent review of the recipe for making ground beef pureed and interview with COOK M, on 2/26/25 at 2:35 p.m., COOK M verified that the recipe for making ground beef pureed was not followed which could affect the food taste, and she acknowledged to follow the recipe next time. During the concurrent review of the recipe for making ground beef pureed and interview with the DM on 2/26/25 at 2:38 p.m., the DM verified that the recipe for making ground beef pureed was not followed and would remind COOK M to follow it next time. During an interview with the RD on 2/28/25 at 8:54 a.m., the RD verified that COOK M should have followed the recipe in making ground beef pureed and she would do an in-service with the kitchen staffs about it. During an interview with the DON on 2/28/25 at 5:35 p.m., the DON acknowledged the finding and would follow up on it. Review of the facility's policy titled, Regular Pureed Diet, dated 2023 indicated, All foods are prepared in a food processor or blender, except for foods, which are normally in a soft and smooth state such as pudding, ice cream Additional liquid is added in the form of broth, gravy, vegetable or fruit juices, or milk to achieve the appropriate consistency. Water is not used because it dilutes flavors and results in a poorly accepted product Review of the facility's policy and procedure titled, Standardized Recipes, revised April 2007 indicated, Standardized recipes shall be developed and used in the preparation of foods Standardized recipes will be adjusted to the number of portions required for a meal

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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** 44185 Based on observation, interview, and record review, the facility failed to ensure food items were stored and prepared in accordance with professional standards for food safety when: 1.The food items that were out of their original boxes and stored in the food containers, were not labeled with open dates and use by dates, and 2. The kitchen staff did not wear his face mask properly while preparing the desserts for the residents. These failures had the potential to cause the growth of micro-organisms which could cause foodborne illness (illness resulting from contaminated food) and cross-contaminated food for the 138 residents who received foods from the facility kitchen. Findings: 1. During the initial kitchen tour observation on 2/23/25 at 9:48 a.m., there were packets of sugar, chocolate powder, coffee creamers, coffee powders, tea and cookie bars that were taken out of their boxes, placed in the storage containers of the preparation area, and they were not labeled with open dates and use by dates. During an interview with the assistant dietary manager (ASSTDM), who was assisting me with the kitchen tour observation on 2/23/25 at 9:50 a.m., the ASSTDM verified that the food items were not labeled, and they should have labeled them with open dates and use by dates. During an interview with the registered dietitian (RD), on 2/28/25 at 8:54 a.m., the RD verified that food stuffs that were taken out of their boxes including packets of sugar, chocolate powder, coffee creamers, coffee powders, tea and cookie bars should be labeled with open dates and use by dates, and she would remind the kitchen staffs about it. During an interview with the director of nursing (DON), on 2/28/25 at 5:35 p.m., the DON verified the above findings and would follow up on it. Review of the facility's policy and procedure titled, Food Receiving and Storage, revised October 2017, indicated, Foods shall be received and stored in a manner that complies with safe food handling practices Dry foods that are stored in bins will be removed from original packaging, labeled and dated (use by date). Such foods will be rotated using a first in - first out system 2. During the concurrent initial kitchen tour observation and interview with cook assistant N (CA N) on 2/23/25 at 10:00 a.m., CA N was observed not wearing his face mask properly with his nose exposed and only covering his mouth while preparing desserts for the residents. CA N acknowledged that he was not wearing his face mask properly and corrected it right away. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the ASSTDM, who was also around at that time, on 2/23/25 at 10:02 a.m., the ASSTDM verified that CA N was not wearing his face mask properly and reminded CA N to always wear it properly. During an interview with the RD on 2/28/25 at 8:54 a.m., the RD verified that kitchen staffs should wear their face masks properly, covering properly their nose and mouth, when preparing foods and she would do an in-service with the kitchen staffs about it. During an interview with the DON, on 2/28/25 at 5:35 p.m., the DON verified the finding and would check on it. Review of the facility's policy following the policy of the County of Santa [NAME] titled, Health Services Agency, dated September 18, 2024 indicated, Order of the health officer requiring use of face masks indoors by all personnel and visitors in acute care facilities, skilled nursing facilities during respiratory virus season

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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 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. 46001 Based on observation, interview, and document review, the facility failed to comply with Federal and State laws and regulations when the approval letter for staffing waiver was not posted where visitors and residents could easily read. This failure had the potential to result in nurse staffing misinformation about residents' care. Findings: During an observation on 2/28/25 at 11:54 a.m., in front of the facility's glass covered cork board, the approval letter for the staffing waiver was not posted. During a concurrent observation and interview with the facility administrator (ADM) on 2/28/2025 at 11:56 a.m., in front of the facility's glass covered cork board, the ADM confirmed the approval letter for staffing waiver should have been posted on the board. During an interview on 03/03/25 at 01:58 p.m. with the staffing coordinator (SC), the SC stated the facility had a staffing waiver. Review of the staffing waiver's approval letter dated 6/18/2024, it indicated, Your request is approved and valid from July 1, 2024, until June 30, 2025, under the following conditions: 1. This approval letter shall be posted immediately adjacent to the facility's license. The facility shall provide written notice of the approved waiver to all residents prior to the execution of an admission agreement. The notice shall be a true copy of the approval letter.

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	056065	A. Building B. Wing	03/03/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on observation, interview, and record review, the facility failed to implement infection control measures when: 1. A dirty pair of gloves were found inside Resident 287's room floor; 2. Resident 72's used urinal (a plastic bottle for urination) was found on top of the overbed table; 3. Resident's used basins, bedpans (a container used to collect urine or feces), urinals and water pitcher were not labeled, cleaned/disinfected, and stored properly; 4. Certified nursing assistant P (CNA P) did not perform hand hygiene in between resident's meal set up; 5. Two nursing staff touched and opened two medication capsules without wearing gloves; 6. A nursing staff failed to perform hand hygiene between medication administration for residents; 7. One of three medication carts was observed with yellow and brown substances on the bottom drawer; 8. Resident 388's peripherally inserted central catheter (PICC, long, soft, flexible tubes inserted into a vein in the upper arm to administer fluids or medications) line dressing was not changed in a timely manner; and 9. A bag of dirty linens was found at the hallway's floor. These failures had the potential to result in the transmission and spread of infection throughout the facility. Findings: 1. During an observation on 2/23/2025 at 10:23 a.m., inside Resident 287's room, a pair of used transparent gloves were observed on the floor beside a linen container. This observation was captured in a photo with the use of a state phone. During a concurrent interview with the director of nursing (DON) and picture review on 2/25/2025 at 10:29 a.m.,the DON reviewed the picture taken during the above observation. The DON confirmed used gloves should not be left on the floor. The DON stated used gloves should be disposed properly in the garbage inside the room. During a review of the facility's policy and procedure titled, Personal Protective Equipment - Using Gloves, dated 9/2010, indicated, Removing Gloves .Discard the glove into the designated waste receptacle inside the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow up interview with CNA R and photo review on 2/24/2025 at 9:06 a.m., CNA R reviewed the photos of BR AA, BR CC, BR DD, and BR EE taken on 2/23/2025 and confirmed the unlabeled bedpans, basins and urinals and stated these should be labeled and stored in their designated storage areas. CNA R stated the used urinals should be hung in the blue holder, at the side of the resident's bed. During a concurrent observation and interview with NS D on 2/24/2025 at 9:35 a.m., inside Bathroom GG, an unlabeled urinal was observed hanging in a pipe. NS D confirmed the observation and stated the urinal should be labeled since BR GG was shared by two residents. During a follow up interview with NS D and photo review on 2/24/2025 at 9:37 a.m., NS D reviewed the photos of BR AA, BR CC, BR DD, and BR EE taken on 2/23/2025 and confirmed basins, and bedpans should not be stored on the floor. NS D stated the water pitcher found in BR EE should not be stored inside BR EE. NS D further stated urinals should be hung at the side of resident's beds. During a concurrent observation and interview with licensed vocational nurse S (LVN S) on 2/24/2025 at 10:03 a.m., inside Bathroom HH (BR HH), one unlabeled bedpan and three unlabeled basins were in BR HH's floor under the sink. LVN S confirmed above observation. LVN S stated the bedpan and basins should have been labeled and stored under resident's closet. LVN S confirmed BR HH was shared by three residents. During an interview with the DON on 2/25/2025 at 10:02 a.m., the DON stated bedpans, basins and urinals should be stored under resident's bedside drawer after being cleaned and dried. The DON further stated resident's bedpans, basins and urinals should be labeled with resident's room number and initials. During a review of the facility's policy and procedure titled, Cleaning and Disinfecting Non-Critical Resident-Care Items, date revised 6/2011, indicated, Single resident use items are for single resident use only. [NAME] with the resident's room number and discard upon transfer or discharge .Bedpans/Urinals .3. Rinse bedpan or urinal with cool water to remove feces and urine. 4. Wash surface of bedpan or urinal with disinfectant solution. 5. Rinse with hot running water .10. Place article on paper towel and allow to air dry or dry article with paper towel .13. Return the bedpan or urinal to resident's bedside cabinet. 4. During observation on 2/23/2025 at 1:08 p.m., in Station II, CNA P was carrying Resident 294's meal tray and went inside Resident 294's room. CNA P set up Resident 294's meal tray and stepped out of the room without hand hygiene. CNA P took Resident 90's lunch tray from the food cart and served it to Resident 90. CNA P stepped out of Resident 90's room and did not perform hand hygiene. CNA P prepared a coffee located on top of the food cart, then checked other resident's lunch trays by touching them and went back to Resident 90's room to serve her coffee. CNA P stepped out of Resident 90's room, still did not perform hand hygiene and went straight to Room JJ to check if residents had their lunch trays. CNA P went out of Room JJ without performing hand hygiene. During an interview with CNA P on 2/23/2025 at 1:10 p.m., CNA P confirmed the above observations and stated she should have performed hand hygiene in between resident's meal set up or every time she stepped out of resident's rooms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the DON on 2/25/2025 at 10:36 a.m., the DON stated staff should perform hand hygiene in between resident's meal set up. The DON further stated if their hands were soiled, they should wash their hands with soap and water, but if their hands were not soiled, they could use the hand sanitizers. During a review of the facility's policy and procedure titled, Handwashing/Hand Hygiene, dated 10/2023, indicated, This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections .All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. 27000 5a. During a medication administration observation with Registered Nurse (RN) F on 2/24/25 at 8:43 a.m., she was observed preparing 9 medications, including 1 capsule of tamsulosin (medication for enlarged prostate) 0.4 milligrams (mg, unit of measurement), for Resident 296. RN F was observed crushing the pills. After finish crushing the pills, she opened the tamsulosin capsule with her bare hands. During an interview witth RN F on 2/25/25 at 9:08 a.m., when asked about opening capsules without wearing gloves, she stated, I thought because I don't touch the medication inside I don't need to wear gloves. She stated she just touched the outside capsule. 5b. On 2/24/25 at 9:09 a.m., upon meeting with licensed vocational nurse (LVN) C at the Station 3 Medication Cart, LVN C had already prepared multiple medications for Resident 43. She was observed picking a green capsule from a medication cup, and opening it to pour the contents inside the capsule back into the medication cup, while not wearing gloves. During an interview with LVN C on 2/24/25 at 9:58 a.m., she stated she should have worn gloves when opening capsules. During an interview with the Director of Nursing (DON) on 2/25/25 at 12:42 p.m., she stated, because of infection control, nurses need to wear gloves when opening the capsules regardless they touch the inside contents or not. 6. During a medication administration observation with LVN C on 2/24/25 at 9:22 a.m., LVN C was observed preparing and administering 4 medications (total of 6 solid pills) with applesauce to Resident 6. At the bedside, the resident swallowed the applesauce but not the medications. She pushed the large pills out of her mouth using her tongue. LVN C took the medications from the resident's mouth with her bare hands. On 2/24/25 at 9:26 a.m., LVN C returned to the medication cart, disposed of the rejected medications, and prepared new medications for the resident. This time she crushed and mixed them in applesauce. On 2/24/25 at 09:29 a.m. LVN C returned to the resident's bedside and spoon-fed the resident the medication-applesauce mixture. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/24/25 at 9:32 a.m., LVN C returned to the medication cart and started preparing medications for the next resident, Resident 47. LVN C did not perform hand hygiene, such as washing or sanitizing her hands, after the medication administration for Resident 6. During an interview with LVN C on 2/24/25 at 10:02 a.m., LVN C stated she did not sanitize her hands after giving medications to Resident 6. She stated she sanitized her hands before but not after the medication administration. A review of the facility's P&P titled Medication Administration, dated 24/2019, indicated, Staff follows established facility infection control procedures (e.g., handwashing, aseptic technique, gloves .) for the administration of medications, as applicable. 7. During an inspection of Station 4 Medication Cart on 2/24/25 at 10:57 a.m. with LVN E, the bottom drawer of the medication cart was observed saturated with sticky yellow and brown stains and debris. LVN E acknowledged the medication cart was not clean. A review of the facility's P&P titled Storage of Medications, dated 4/2007, indicated, The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner. 46001 8. A review of Resident 338's clinical record indicated he was admitted to the facility on [DATE] with diagnoses including pneumonia (an infection that inflames the air sacs in one or both lungs) due to streptococcus pneumoniae(a contagious infection caused by bacteria)and unspecified organism sepsis. A review of Resident 338's clinical record indicated a physician's order, dated 2/17/2025, for PICC Line dressing change: right upper arm every day shift every 7 days for PICC line dressing. During an observation in Resident 338's room on 2/26/2025 at 10:29 a.m., Resident 338 was lying in bed. His PICC line dressing was dated 2/17/2025. During a concurrent interview and record review with the Director of Staff Development (DSD) on 2/26/2025 at 11:33 a.m., the DSD reviewed Resident 338's physician's order and confirmed that Resident 338 had a physician order to change his PICC line dressing every 7 days. The DSD also stated that the registered nurses should have changed this PICC line dressing on 2/24/2025 to prevent infection. A review of the facility's policies and procedures, titled Mid-line, PICC line, and Central Dressing Changes, indicated .change catheter dressing 24 hours after catheter insertion, every 5-7 days, or if it is wet, dirty, not intact, or compromised in any way. 9. During an observation with the Infection Preventionist (IP) on 2/28/2025 at 12:09 p.m., in the hallway near the laundry room, a big plastic bag with dirty linen was sitting in the hallway. During an interview with the IP on 02/28/25 at 12:20 p.m., the IP stated the staff should not have left a dirty linen bag on the hallway floor to prevent infection.