STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056104	A. Building B. Wing	04/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Villa Health Care Center	9028 Rose Street Bellflower, CA 90706

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906 Based on observation, interview, and record review the facility failed to ensure the call lights for two out of four residents sampled (Residents 8 and 155) were within reach. The deficient practice had the potential to result in delayed care and services that promote the residents' well-being. Findings: During a review of Resident 8's Admission record, dated 4/6/2024, the admission record indicated Resident 8 was initially admitted to the facility on [DATE] and recently readmitted to the facility on [DATE] with diagnoses including muscle weakness, schizophrenia (mental illness that affects how a person thinks, feels and behaves), diabetes mellitus (disorder where the body cannot regulate glucose or sugar like it should), and dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). During a review of Resident 8's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 3/7/2024, the MDS indicated Resident 8 had severe impairment in cognitive (thinking reasoning, remembering) skills for daily decision making. The MDS indicated Resident 8 needed set up assistance with eating, supervision with personal hygiene, and substantial assistance from staff, where staff does more than half the effort, with oral hygiene. During a review of Resident 155's Admission record, dated 4/6/2024, the admission record indicated Resident 155 was admitted to the facility on [DATE] with diagnoses including aftercare following joint (the part of the body where two or more bones meet to allow movement) replacement surgery, presence of right artificial hip joint, cognitive communication deficit, dementia, and history of falling. During a review of Resident 155's MDS, dated [DATE], the MDS indicated Resident 8 had moderate cognitive impairment. The MDS indicated Resident 155 needed set up or clean up assistance with eating, oral hygiene, and personal hygiene, and Resident 155 needed substantial assistance where helper does more than half the effort with toilet hygiene and upper body dressing. The MDS indicated Resident 155 was dependent on staff where helper does all the effort with showering, lower body dressing and putting on or taking off footwear. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 4/06/2024 at 8:17 a.m., with Licensed Vocational Nurse 4 (LVN 4), at Resident 8 and 155's room, Resident 8's call light was noted hanging on Resident 8's headboard and Resident 155's call light was hanging on the wall away from Resident 155's reach. LVN 4 stated Resident 8 and 155's call lights were out of their reach and needed to be closer and accessible to the residents so they could call if they needed help. LVN 4 proceeded to place the call lights within Resident 8 and 155's reach. During an interview with the Director of Nursing (DON) on 4/7/2024 at 5:40 p.m., the DON stated the residents' call lights need to be within reach to ensure their needs were met. During a review of the facility's policy and procedure titled Call light/Bell, revised 5/2007, the policy indicated it was the facility policy to provide the residents a means of communication with nursing staff. The policy indicated the call device need to be within the residents' reach.

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906 Based on interview and record review the facility failed to ensure one of one sampled residents (Resident 37's) 7-day-bed-hold (a guaranteed reservation for residents that are transferred out emergently) was honored, by admitting a new resident to Resident 37's bed. This deficient practice violates Resident 37's right to come back to his guaranteed bed and is against the facility's policy and procedure for bed hold. Findings: During a record review of Resident 37's Admission Record, the Admission Record indicated the resident was admitted on [DATE] then readmitted on [DATE] to the facility with diagnoses that included acute respiratory failure with hypoxia (often caused by a disease or injury that affects your breathing, such as pneumonia, opioid overdose, stroke, or a lung or spinal cord injury), essential primary hypertension (occurs when you have abnormally high blood pressure that's not the result of a medical condition). During a record review of Resident 37's Minimum Data Set ([MDS] standardized screening and care planning tool) dated 3/6/2024, the MDS indicated the resident had the capacity to understand others and was able to be understood by staff. The MDS indicated Resident 37 required maximal assistance (helper does more than half the effort) from one staff for toileting hygiene, dressing, transfer, bed mobility, and supervision or touching assistance (helper provides verbal cues and /or touching/contact guard assistance) from one staff for eating. During a record review of the census (a complete count of residents admitted to the facility) dated 4/4/2024, the census indicated the facility had 4 beds that were on bed hold. During an interview on 4/6/2024 at 3:45 p.m., and record review of the census dated 4/4/2024 with the receptionist, the receptionist stated she is responsible for updating the census daily. The receptionist stated that she updates the census if there is a new admission or a discharge to reflect the accurate number of residents in the facility and the residents on bed-hold. The receptionist added that she also counts the days of the bed-hold, so she knows when to make the beds available for new admissions. The receptionist stated she makes beds that should be on-hold available to new admissions by asking the Director of Nursing for permission so they can continue to admit new residents. The receptionist stated she is not aware if that is okay, but she follows what the DON or Administrator tell her to do. During a review of Resident 37's medical record, the medical record indicated a physician's order dated 3/30/2024 at 3:25 p.m., to transfer Resident 37 to the General Acute Care Hospital (GACH) emergency room due to a critical laboratory result (a medical test result that requires transfer to the GACH). During a record review of Resident 37's medical record, the medical record indicated a physician's order dated 4/4/2024 at 12:07 a.m., for a bed-hold for 7 days. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview on 4/6/2024 at 2:35 p.m., and record review of the census dated 4/4/2024 with the Director of Nursing (DON), the DON stated every time the facility sends a resident to the hospital there is a 7-day-bed-hold which means that the bed will be on-hold for the resident in case they come back within the 7-days they can have their own bed back. The DON stated that the medical insurance pays to reserve that bed for the resident. The DON stated that Resident 37's bed that is on bed hold is room [ROOM NUMBER]A, which is now occupied by another newly admitted male resident. The DON stated if the hospital were to transfer Resident 37 back to the facility there would be no available bed for him because his bed was occupied by another resident while Resident 37 was on bed hold. During a record review of the facility census dated 4/3/2024 Resident 37 was in bed 10 A on Day 4 of bed-hold, on 4/4/2024 day 5 of the bed-hold, a new resident was admitted to bed 10A. During a continued interview and record review of the facility's census dated 4/1/2024 through 4/6/2024, on 4/6/2024 at 2:55 p.m., with the DON, the DON stated the facility accommodates newly admitted residents by giving away beds that are on bed-hold. The DON stated that the Centers for Medicare and Medical Services (a federal health insurance agency) pays the facility to reserve the residents' bed for 7 days. The DON further added that it is residents' rights to hold the bed while they are in the GACH and the facility should not give it to a new resident while the bed is still on hold. During a review of the facility's policy and procedure (P&P) titled Bed hold dated 12/2023, the P&P indicated the resident or resident's representative will be notified in writing of the right to exercise the bed hold provision of 7 days upon admission and provide a second notice before transfer to a general acute care hospital or before the resident goes on therapeutic leave. In the event of an emergency transfer, the second notice will be provided within 24 hours. A copy of this notification shall become a part of the resident's health record at the time of transfer. Each notice shall include the duration of the state bed- hold policy that the resident's bed will be held for the duration of 7 days, during which time the resident is permitted to return and resume residence in the facility, it also includes the amount require to be paid by the resident to hold the bed for the duration of the bed-hold period.

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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 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** 45028 Based on interview and record review, the facility failed to provide treatment and services to maintain or prevent further decrease in joint range of motion (ROM, full movement potential of a joint) and/or mobility for four of 12 sampled residents (Resident's 11, 20, 30, and Resident 43). The facility failed to ensure that Resident's 11, 20, 30 and Resident 43 received Restorative Nursing Aide (RNA, nursing aide program that helps residents maintain their function and joint mobility) treatment five times a week as indicated in the residents' care plans. This deficient practice had the potential for Resident's 11, 20, 30 and Resident 43 to have an avoidable decline in range of motion and mobility. a. During a review of Resident 11's Admission Record (Face Sheet), the Face Sheet indicated the resident was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including major depressive disorder (a mood disorder which causes a persistent feeling of sadness and loss of interest), dementia (the loss of thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life activities), osteoarthritis (tissues in the joint [part of the body where two or more bones meet to allow movements] break down over time), and muscle wasting (a weakening, shrinking, and loss of muscle caused by disease or lack of use). During a review of Resident 11's Minimum Data Set ([MDS] a standardized assessment and care-screening tool) dated 2/7/2024, the MDS indicated Resident 11's cognition (ability to make decisions of daily living) was moderately impaired and was always able to understand and be understood by others. The MDS indicated Resident 11 required substantial/maximum assistance (helper lifts or holds trunk or limbs and provides more than half the effort) from staff for toileting hygiene, showering/bathing, upper body dressing, and lower body dressing. The MDS indicated Resident 11 was totally dependent (resident does none of the effort to complete the activity) for rolling left to right in bed, sitting to lying in bed, lying to sitting on the side of the bed, toilet transfer, and for tub/shower transfer. The MDS indicated Resident 11 did not walk during the assessment period. During a review of Resident 11's untitled Care Plan, initiated on 9/22/2018, the Care Plan indicated Resident 11 was identified to have an activity of daily living (ADL) self-care performance deficit related to confusion, poor communication, gait/balance (manner of walking) problems dementia, and depression. The Care Plan goal indicated Resident 11 will maintain current level of function through the review date of 5/18/2024. The Care Plan interventions for Resident 11 included for RNA to assist with bilateral (both) upper (UE) and lower extremity (LE) exercises in all planes (moving side-to-side, front, and back, or rotationally) as tolerated five times a week. During a review of Resident 11's Order Summary Report (Physician's Orders), the Physician's orders indicated an order was placed on 4/1/2024, for RNA to assist with bilateral upper and lower extremity exercises in all planes as tolerated every day shift, five times a week. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 11's RNA Treatment Flow Sheet dated April 2024, the RNA Treatment Flowsheet indicated there was no documentation on 4/1/2024, and from 4/5/2024 to 4/7/2024 that Resident 11 had received RNA therapy. The Treatment Flow Sheet Indicated RNA treatment was not completed as five times a week as ordered. b. During a review of Resident 12's Face Sheet, the Face Sheet indicated Resident 12 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including difficulty in walking, muscle weakness, major depressive disorder, and Alzheimer's disease (a brain disorder which slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks). During a review of Resident 12's History and Physical (H&P) dated 2/3/2023, the H&P indicated Resident 12 did not have the capacity to understand and make decisions. During a review of Resident 12's MDS dated [DATE], the MDS indicated Resident 12's cognition was moderately impaired and was usually understood and was usually able to understand others. The MDS indicated Resident 12 required substantial/maximum assistance from staff for toilet transfer, tub/shower transfer, toileting hygiene, and shower/bathing. The MDS indicated Resident 12 did not walk during the assessment period. During a review of Resident 12's untitled Care Plan, initiated on 2/8/2022, the Care Plan indicated Resident 12 was identified to have an ADL self-care performance deficit related to depression and Alzheimer's dementia. The Care Plan goal indicated Resident 12 will maintain current level of function through the review date of 4/14/2024. The Care Plan interventions for Resident 12 included for RNA to assist with range of motion ([ROM] activity aimed at improving movement of a specific joint) and ambulation as ordered. During a review of Resident 12's Physician's Orders, the Physicans Orders indicated an order dated 4/1/2024, for RNA to assist with bilateral upper and lower extremity exercises in all planes as tolerated every day shift, five times a week. During a review of Resident 12's RNA Treatment Flow Sheet dated April 2024, the RNA Treatment Flowsheet indicated there was no documentation on 4/1/2024, and from 4/5/2024 to 4/7/2024. The RNA Treatment Flow Sheet Indicated RNA treatment was not completed five times a week as ordered. c. During a review of Resident 30's Admission Face Sheet, the Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses including rheumatoid arthritis (the body attacks itself and damages the joints), polyneuropathies (the simultaneous malfunction of many peripheral [away from the center of the body] nerves [carry messages to and from the brain and spinal cord] throughout the body), muscle weakness, abnormalities of gait and mobility, and abnormal posture. During a review of Resident 30's H&P dated 2/10/2024, the H&P indicated Resident 30 had the capacity to understand and make decisions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 30's MDS dated [DATE], the MDS indicated Resident 30's cognition was intact and was always able to understand and be understood by others. The MDS indicated Resident 30 required substantial/maximum assistance from staff for rolling left to right in bed, sitting to lying in bed, and lying to sitting on the side of the bed. The MDS indicated Resident 30 was totally dependent on staff for eating, oral hygiene, toileting hygiene, shower/bath, upper body dressing, and lower body dressing. The MDS indicated Resident 30 did not walk during the assessment period. The MDS further indicated Resident 30 had functional limitations in ROM on both upper extremities (shoulder, elbow, wrist, hand). During a review of Resident 30's untitled Care Plan, initiated on 2/4/2024, the Care Plan indicated Resident 30 was identified to have an ADL self-care performance deficit related to acute (sudden onset) weakness. The Care Plan goal indicated Resident 30 will maintain current level of function through the review date of 5/4/2024. The Care Plan interventions for Resident 30 included for bilateral upper extremity (BUE) resting hand splints (supports the wrist and joints of the fingers and thumb to make sure they are positioned correctly) for up to two to six hours or as tolerated, with skin checks, before and after splint application five times a week. The Care Plan interventions included BUE and bilateral lower extremities (BLE) exercises in all planes as tolerated five times a week. During a review of Resident 30's Physician's Orders dated 3/7/2024, the Physician's Orders indicated an order was placed for Resident 30 to have BUE and BLE active range of motion ([AAROM] movement at a given joint with a person's own effort and assistance from an external force or another person) exercises in all planes as tolerated every day shift, five times a week, Monday through Friday. During a review of Resident 30's Physician's Orders dated 3/8/2024, the Physician's Orders indicated an order was placed for Resident 30 to have bilateral upper extremity resting hand splints for up to two hours or as tolerated, with skin checks, before and after splint application, every day, five times a week Monday through Friday. During a review of Resident 30's RNA Treatment Flow Sheet dated March 2024, for the RNA order for resident hand splints, there was no documentation on the RNA Treatment Flow Sheet indicating Resident 30 received RNA hand splint application from 3/25/2024 to 3/29/2024. The RNA Treatment Flow Sheet indicated RNA treatments were not completed five times a week as ordered. During a review of Resident 30's RNA Treatment Flow Sheet dated March 2024, the RNA Treatment Flow sheet indicated no documentation for the RNA order for BUE and BLE AAROM exercises, that Resident 30 received BUE and BLE AAROM exercises on 3/28/2024. The RNA Treatment Flow Sheet indicated RNA treatments were not completed five days a week as ordered. During a review of Resident 30's Physician's Orders dated 4/1/2024, the Physician's Orders indicated an order was placed for Resident 30 to have BUE and BLE AAROM exercises in all planes as tolerated every day shift, five times a week. During a review of Resident 30's Physician's Orders dated 4/1/2024, the Physician's Orders indicated an order was placed for Resident 30 to have bilateral upper extremity resting hand splints for up to two to six hours or as tolerated, with skin checks, before and after splint application, every day, five times a week. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/6/2024 with Resident 30, Resident 30 stated, I know my order is to have my hands splinted every day, but I have only had my hands splinted once this week and my bilateral arm and leg exercises have been done only once this week as well. I know both of my orders are for five times a week, but I don't know why I'm not getting my therapy. I am already having problems with my hands, I can't feed myself, and I'm afraid I'm going to get worse if I don't get my therapy, that is what I'm here for, right? During a follow-up interview on 4/7/2024 at 4:25 p.m. with Resident 30, Resident 30 stated, I didn't receive my therapy yesterday or today. I thought maybe I would get my therapy later in the day yesterday, but it never happened. Today I didn't get my therapy either. I don't know why it wasn't done. d. During a review of Resident 43's Face Sheet, the Face Sheet indicated Resident 43 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including left femur (thigh bone) fracture (broken bone), abnormalities of gait and mobility, and dementia. During a review of Resident 43's History and Physical (H&P) dated 2/22/2024, the H&P indicated Resident 43 did not have the capacity to understand and make decisions. During a review of Resident 43's MDS dated [DATE], the MDS indicated Resident 43's cognition was intact and was usually understood and was usually able to understand others. The MDS indicated Resident 43 required substantial/maximum assistance from staff for sitting to standing, chair to bed/bed to chair transfer, toilet transfer, toileting hygiene, tub/shower transfer, and shower/bathing. The MDS indicated Resident 43 could only walk 10 feet (once standing, the ability to walk 10 feet in a room, corridor, or similar space) with substantial/maximum assistance from staff during the assessment period. The MDS further indicated Resident 43 had lower extremity impairment on one side. During a review of Resident 43's untitled Care Plan, initiated on 3/20/2024, the Care Plan indicated Resident 43 was identified to have an ADL self-care performance deficit related to dementia and history of depression. The Care Plan goal indicated Resident 43 will maintai functional abilities through the review date of 6/18/2024. The Care Plan interventions for Resident 43 included for BUE and BLE ROM exercises in all planes as tolerated five times per week. During a review of Resident 43's Order Summary Report (Physician's Orders), an order was placed on 4/1/2024, for RNA to assist with BUE and BLE exercises in all planes as tolerated every day shift, five times a week. During a review of Resident 43's RNA Treatment Flow Sheet dated April 2024, the RNA Treatment Flowsheet indicated the documentation section was blank on 4/1/2024, 4/5/2024, and 4/7/2024. The RNA Treatment Flow Sheet Indicated RNA treatment was not completed five times a week as ordered. During an interview on 4/6/2024 at 3:50 p.m., with the Director of Rehab (DOR) the DOR stated, residents receive RNA services to maintain their ROM, and to prevent further decline. If residents are not getting RNA therapy as ordered by the physician that places the residents at risk for further decline, and contractures (a permanent tightening of the muscles, tendons [a tough band of dense fibrous connective tissue which connects muscle to bone], skin, and nearby tissues which cause the joints to shorten and become very stiff). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on 4/7/2024 at 5:39 p.m., the DON stated, The purpose of implementing the resident's care plan interventions is to help prevent resident's further health decline. It is the responsibility of the nursing staff to implement the resident's care plan interventions as indicated. By not following the RNA interventions, it puts the residents at risk for further decline in mobility. The RNA was not available for interview during the period the recertification survey was conducted. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, revised 12/2023, the P&P indicated a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The P&P indicated the interventions are actions, treatments, procedures, or activities which are designed to meet an objective. CROSS REFERENCE TO F688

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906 Based on observation, interview, and record review, Licensed Vocational Nurse (LVN) 3 failed to check for gastrostomy tube ([G-tube] a surgical opening made into the stomach to provide nutritional support) placement (the correct positioning or location of something) and patency (being open) per the physician's orders, prior to administering medications for one of one sampled residents (Resident 1). This deficient practice placed Resident 1 at risk for peritonitis (inflammation, swelling of the lining of the belly or abdomen), pain, and unnecessary hospitalization from administering medications into a G-tube which may have been dislodged. Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including cerebral palsy (a group of permanent movement and posture disorders which limit activity), abnormalities of gait and mobility, abnormal posture, and seizures (sudden, uncontrolled body movements and changes in behavior which occur because of abnormal electrical activity of the brain). During a review of Resident 1's History and Physical (H&P) dated 10/18/2023, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care-screening tool) dated 1/18/2024, the MDS indicated Resident 1's cognitive (ability to make decisions of daily living) skills for daily decision making were severely impaired and Resident 1 was never understood and was never able to understand others. During a review of Resident 1's Order Summary Report (Physician's Orders, the Physician's Orders indicated an order was placed on 10/16/2023 for the licensed nurses to check Resident 1's feeding tube placement and patency before and after giving medications, before starting feedings, and every shift. During an observation on 4/7/2024 at 9:13 a.m., in Resident 1's room, with LVN 3, LVN 3 was observed preparing to administer the following medications: 1. Lactulose Oral Solution 10 grams (a metric unit of mass equal to one thousandth of a kilogram)/15 milliliter ([mL] a unit of measure of volume), 30 mL every four hours for high ammonia (a waste product that bacteria in the intestines make when digesting protein [a nutrient that the body needs to grow and maintain itself]) level. 2. Cholecalciferol Tablet 1000 units (a measurement), give one tablet one time a day for supplement. 3. Folic Acid 1 milligrams ([mg] - a unit of measure of weight) tablet, give one tablet one time a day for supplement. (continued on next page)

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	056104	A. Building B. Wing	04/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Villa Health Care Center	9028 Rose Street Bellflower, CA 90706

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Keppra Oral Solution 100 mg /mL, give 15 mL every 12 hours for seizure disorder. 5. Senna Oral Tablet, give 2 tablets twice a day for bowel management. 6. Lamotrigine Oral Tablet 25 mg, give 1 tablet every 12 hours for seizure disorder. 7. Multiple Vitamin and Mineral, give 5 mL daily for supplement. 8. Lacosamide 10mg/mL, give 20 mL every 12 hours for seizure disorder. During a continued observation on 4/7/2024 at 9:18 a.m., in Resident 1's room, with LVN 3, LVN 3 was observed administering medications to Resident 1. LVN 3 did not check for G-tube patency or placement prior to administering Resident 1's medications. During an interview on 4/7/2024 at 9:28 a.m., with LVN 3, LVN 3 stated, she forgot to check Resident 2's G-tube for placement and patency prior to administering Resident 1's medications. LVN 3 stated the process of checking the G-tube for patency and placement includes injecting 10mL of air into the G-tube, auscultating (listening to) the abdomen (stomach area) with a stethoscope (medical device used to listen to internal body sounds) and withdrawing gastric residual (stomach contents) from the G-tube. LVN 3 stated that if you hear a whooshing sound while injecting the air into the G-tube site, then the placement is correct. By withdrawing gastric residual from the G-tube you are also able to check for correct placement and patency. During an interview on 4/7/2024 at 5:39 p.m. with the Director of Nursing (DON), the DON stated, that licensed nurses must check for G-tube placement and patency prior to administering medications to a resident. The DON state that the purpose of checking the G-tube is to ensure the G-tube is in the correct place and it is patent. If the licensed nurses don't check for correct placement or patency, and the G-tube is dislodged (displacement of a device), there is a potential for the medications being administered directly into the peritoneum (the tissue which lines the abdominal wall and cavity) which could lead to infection and unnecessary hospitalization . During a review of the LVN Job Description, dated 12/17/2021, the Job Description indicated the LVN's essential duties and responsibilities included the following: 1. Implementing and maintaining established policies, procedures, objectives .and infection control. 2. Administering services within the applicable scope of nursing practice, which may include catheterization, tube feedings, suctions .etc., as appropriate and in accordance with applicable standards. During a review of the facility's policy and procedure (P&P), titled Medication Administration, Enteral Tubes, dated 2012, the P&P indicated to verify tube placement by inserting a small amount of air into the tube with the syringe and listen to the stomach with a stethoscope for gurgling sounds and to aspirate stomach contents with a syringe.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on observation, interview, and record review the facility failed to provide quality of care and services in accordance with professional standards of practice for one of three residents (Resident 8) when: 1. The facility failed to ensure the physician and the Registered Dietician ([RD] a health professional who has special training in diet and nutrition) were notified immediately, as indicated in the nutrition care plan, after Resident 8 was identified with severe weight loss on 2/5/2024 and 4/5/2024. a. On 2/5/2024, Resident 8 was identified to have a 9.73 % weight loss and the physician and RD were notified of the weight loss on 2/8/2024, three days later. b. On 4/5/2024, Resident 8 was identified to have 7.7 % weight loss and the physician and RD were notified of the weight loss on 4/6/2024, a day after the weight loss was identified. 2. The facility failed to ensure the Interdisciplinary team's ([IDT] resident's health care team consisting of various specialties) recommendations made on 2/8/2024 were implemented in a timely manner. The IDT recommendations were made on 2/8/2024, three days after the weight loss was identified on 2/5/2024 and the recommendations were ordered twelve days after the weight loss was identified on 2/17/2024. a. Resident 8's order for Boost Glucose Control (nutritional supplement) was not ordered and Resident 8 did not receive the supplement until 2/17/2024, twelve days after weight loss was identified. The resident was not provided a total of 380 kilocalories (kcal, a unit of measure) and 32 grams of protein per day for approximately twelve days. b. Resident 8's order for Megestrol Acetate Suspension (appetite stimulant) was placed and carried out on 2/17/2024 and Resident 8 did not receive the appetite stimulant until twelve days after weight loss was identified. c. The No Added Salt (NAS) portion of the diet for Resident 8 was removed from the diet order on 2/17/2024, twelve days after the weight loss was identified. 3. The facility failed to ensure Resident 8's amount eaten for every meal was recorded as indicated in the care plan intervention, initiated on 9/10/2023, and IDT recommendation to monitor resident intake on 2/8/2024. From 2/7/2024 to 3/7/2024 and 3/9/2024 to 4/6/2024, out of 177 meals 50 meals were not monitored and the amount eaten by Resident 8 was not recorded. 4. The facility failed to ensure Resident 8 received the ordered Consistent Carbohydrate Diet (CCHO, diet with the same amount of carbohydrates [sugars], main nutrients in our diet, every day), regular texture, thin liquids consistency, fortified, with chopped meat. On 4/7/2024, Resident 8 was served CCHO diet, regular texture, thin liquids consistency, fortified (extra nutrients added), with chopped meat and with no added salt (NAS). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. The facility failed to ensure the Nutrition care plan was updated in a timely manner after the severe weight loss was identified on 2/5/2024 and the IDT made recommendations on 2/8/2024; The Nutrition care plan was updated on 3/5/2024, a month after the severe weight loss was identified. These deficient practices resulted in Resident 8 having insidious (gradual unintended weight loss over time) severe weight loss of 7.7 % in one month (March to April) and 15% weight loss in three months (January to April) due to lack of monitoring and delayed interventions and placed Resident 8 at higher risk for malnutrition (body does not get enough nutrients), poor wound healing and feelings of depression (mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with daily life). On 1/5/2024, Resident 8 weighed 113 lbs. and on 4/5/2024, Resident 8 weighed 96 lbs. The resident lost a total of 37 lbs. from 1/5/2024 to 4/5/2024. Findings: During a review of Resident 8's Admission record, dated 4/6/2024, the admission record indicated Resident 8 was initially admitted to the facility on [DATE] and recently readmitted to the facility on [DATE] with a diagnoses including sepsis (infection of the blood), muscle weakness, dysphagia (difficulty swallowing), mild calorie protein-calorie malnutrition (nutritional status in which reduced availability of nutrients leads to changes in body composition and functions), schizophrenia (mental illness that affects how a person thinks, feels and behaves), diabetes mellitus (disorder where the body cannot regulate glucose or sugar like it should), and dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). During a review of Resident 8's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 3/7/2024, the MDS indicated Resident 8 had severe impairment in cognitive (thinking reasoning, remembering) skills for daily decision making. The MDS indicated Resident 8 needed set up assistance with eating, supervision with personal hygiene, and substantial assistance from staff, where staff does more than half the effort, with oral hygiene. The MDS indicated Resident 8 was 64 inches in height and last weighed 104 pounds (lbs.) and the resident had a weight loss of 5 percent or more in the last month. During a review of an untitled care plan, initiated on 12/18/2023, the care plan indicated Resident 8 had a nutritional problem or potential nutritional problem. The care plan indicated the resident will maintain adequate nutritional status as evidenced by maintaining weight greater than 104 lbs. with no signs and symptoms of malnutrition. The care plan interventions indicated the following: a. Initiated on 9/10/2023 and target date 6/14/2024, administer medications as ordered and monitor and report to the physician as needed for any signs and symptoms of decreased appetite. b. Initiated on 9/21/2023 and target date 6/14/2024, if weight decline persists, contact physician and dietician immediately and to monitor and report to the physician as needed any signs and symptoms of decreased appetite. c. Initiated on 3/5/2024 and target date 6/14/2024, provide supplements as ordered Boost Glucose control, twice a day, and diet as ordered by physician. During a review of Resident 8's Weight Summary, the summary indicated the following weights for Resident 8: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. On 1/5/2024, 113 lbs. 2. On 2/5/2024, 102 lbs. (9.7% weight loss in one month) 3. On 3/5/2024, 104 lbs. 4. On 4/5/2024, 96 lbs. (7.7% weight loss in one month and 15% weight loss in three months) During a review of Resident 8's medical record titled Nutrition Interdisciplinary Team Update, dated 2/8/2024 at 5:12 p.m., the Nutrition Interdisciplinary Team Update, indicated Resident 8's most recent weight was 102 lbs. on 2/5/2024 which indicated an 11 lb. weight loss or 9.7%. weight loss in one month. The document indicated Resident 8 was underweight. The IDT recommendations included an appetite stimulant for weight stabilization, continue to monitor weight response, discontinue the No Added Salt (NAS) part of the diet, and continue the rest of the diet as ordered, add Boost Glucose Control (a nutrient rich drink with minimal impact on blood sugar), 237 milliliters (ml- unit of measure of volume) twice a day with med pass (scheduled medication administration) and weekly weights for four weeks. During a review of Resident 8's Order Summary report, as of 4/7/2024, the report indicated on 2/17/2024, for Resident 8 to receive: a. CCHO diet regular texture, thin liquids (no restriction) consistency, fortified (increased nutrients). Chopped meat, b. Boost Glucose Control two times per day for supplement 237 ml with med pass, c. Megestrol Acetate Suspension 400 milligrams/ 10 ml, give 10 ml by mouth, one time a day, for appetite stimulant. During a review of Resident 8's medical record titled, Dietary - Amount Eaten from 2/7/2024 to 3/7/2024, the record indicated 31 meals out of 90 meals were left blank, with no amount eaten documented, indicating meal intake was not monitored. During a review of Resident 8's medical record titled Response History, Amount Eaten from 3/9/2024 to 4/6/2024, the record indicated 19 out of 87 meals were left blank, with no amount eaten documented, indicating meal intake was not monitored. During a review of Resident 8's Medication Administration Record (MAR) for 3/2024, the MAR indicated Resident 8 had the following ordered: a. On 2/17/2024, Megestrol Acetate Suspension 400 mg/10 ml, Give 10 ml by mouth one time a day for appetite stimulant. Resident 8 did not receive the medication from 2/9/2024 to 2/16/2024; there were 8 missed doses. (R8 gained weight during this time (On 2/5/2024, 102 lbs. On 2/16/2024, 105 lbs.) b. On 2/17/2024, Boost Glucose Control, two times per day for supplement, 237 ml with med pass. Resident 8 did not receive the supplement from 2/9/2024 to 2/17/2024 in the morning; there were 17 missed opportunities. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 8's Nutrition Interdisciplinary Team Update, dated 4/6/2024 at 5:31 p.m., the update indicated Resident 8 lost 8 lbs. and had a 7.7% weight loss in one month. The update indicated Resident 8 was underweight, and goal was for Resident 8 to weigh over 104 lbs. The update indicated Resident 8 needed 1590 to 1908 kilocalories (Kcal- unit of energy produced from nutrients). The document indicated Boost Glucose control would provide 190 kcal and 16 grams of protein (nutrient for muscle function), twice a day with med pass. During a concurrent interview with the MDS Registered Nurse (MDS RN) and record review of Resident 8's medical records on 4/6/2024 at 1:01 p.m., the MDS RN stated Resident 8 had had a severe weight loss of 7. 7 % when Resident 8 weighed 104 lbs. on 3/5/2024 to 96 lbs. on 4/5/2024. The MDS RN stated the physician, and the RD should have immediately been notified after the weight loss was identified because Resident 8 was high risk for dehydration and malnutrition. During a concurrent observation and interview on 4/7/2024, at 8:33 a.m., with Registered Dietician 1(RD 1), in Resident 8's room, Resident 8 was eating breakfast without a salt packet on her breakfast tray and the diet profile card indicated Resident 8's diet was CCHO NAS Regular, chopped meat, fortified. The RD stated the diet profile card, food tray, and the order did not match and Resident 8 should have had a salt packet with the resident's breakfast tray. During a concurrent interview and record review on 4/7/2024, at 8:35 a.m., with the RD, Resident 8's Nutrition Interdisciplinary Team Update, dated 2/8/2024 at 5:12 p.m., was reviewed. The RD confirmed Resident 8 had a severe weight loss of 9.7 % on 2/5/2024 when Resident 8 weighed 113 lbs. on 1/5/2024 to 102 lbs. on 2/5/2024. The RD stated the physician and dietician was not aware of the weight loss until 2/8/2024, three days after the weight loss was identified. The RD stated the IDT did not address the severe weight loss immediately and the RD stated the IDT usually addresses severe weight loss within three days. The RD stated the IDT team made recommendations on 2/8/2024 for Boost Glucose Control twice a day with med pass, an appetite stimulant, to remove the NAS portion of the diet for Resident 8, and to continue to monitor the Resident 8's meal intake and weights. During a continued interview and record review on 4/7/2024, at 8:45 a.m., with the RD, Resident 8's MAR for 2/2024 and Resident 8's Order Summary report as of 4/7/2024 were reviewed. The RD confirmed the IDT recommendations were all carried out and ordered on 2/17/2024, twelve days after the weight loss was identified. The RD could not provide an explanation as to why the interventions were all delayed just that it was unacceptable. (The resident gained weight during that time 2. On 2/5/2024, 102 lbs. On 2/16/2024, 105 lbs.). During a continued interview and record review on 4/7/2024, at 8:50 a.m., with the RD, Resident 8's records titled Dietary - Amount Eaten from 2/7/2024 to 3/7/2024 and Response History, Amount Eaten from 3/9/2024 to 4/6/2024 were reviewed. The RD confirmed not all Resident 8's meals were monitored and documented, and we do not know if Resident 8 ate or not on those days. During a continued interview and record review on 4/7/2024, at 8:55 a.m., with the RD, Resident 8's Nutrition Interdisciplinary Team Update, dated 4/6/2024 at 5:31 p.m., was reviewed. The RD confirmed Resident 8 had a severe weight loss of 7.7 % when Resident 8 weighed 104 lbs. on 3/5/2024 to 96 lbs. on 4/5/2024. The RD stated the physician and RD was not notified immediately of the weight loss and was notified the next day on 4/6/2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review with the Infection Preventionist (IP) on 4/7/2024 at 8:35 a.m. Resident 8's Response History, Amount Eaten from 3/9/2024 to 4/6/2024, was reviewed. The IP confirmed 19 out of 87 meals were left blank, with no amount eaten documented, indicating meal intake was not monitored. During a continued interview and record review with the IP on 4/7/2024 at 8:45 a.m., Resident 8's care plans were reviewed. The IP confirmed Resident 8's Nutrition care plan, initiated on 12/18/2023, was updated on 3/5/2024, 30 days after the severe weight loss was identified on 12/5/2024, indicating the recommendations made by the IDT team. The IP did not provide an explanation for the month delay of updating the care plan just that it should have been updated when the weight loss was identified on 2/5/2024. During a follow up interview and record review with the IP on 4/7/2024 at 11:57 a.m., Resident 8's Dietary - Amount Eaten from 2/7/2024 to 3/7/2024, was reviewed. The IP confirmed 31 meals out of 90 meals were left blank, with no amount eaten documented, indicating meal intake was not monitored. The IP stated with no documentation to confirm we do not know if Resident 8 ate or not. The meal intake percentage should have been documented to ensure a clear picture of Resident 8's status. During a follow up interview with the RD on 4/7/2024 at 1:19 p.m., the RD stated Boost Glucose Control 237 ml twice a day equates to 380 kcal and 32 grams of protein per day. From 2/5/2024 to 2/17/2024, Resident 8 did not receive the nutritional supplement that provided the added caloric and protein intake recommended by the IDT team. During an interview with the Dietary Supervisor (DS) on 4/07/2024 at 7:57 p.m., the DS stated she did not do the tray audit for 3/2024 so Resident 8 was served the incorrect order. The DS stated the correct diet should be served to the residents to prevent malnutrition and dehydration. During an interview with the Director of Nursing (DON) on 4/7/2024 at 8:00 p.m., the DON stated Resident 8 had severe weight loss identified on 2/5/2024 and on 4/5/2024 and the physician and dietician should have been notified immediately so the severe weight loss can be addressed sooner. The DON confirmed Resident 8's weight loss was identified on 2/5/2024, the IDT made recommendations on 2/8/2024, and the orders were entered on 2/17/2024, twelve days after the weight loss was first identified. The DON stated the IDT recommendations should have been implemented sooner so Resident 8 can start gaining weight and not lose more weight. The DON confirmed Resident 8's meal intake was not monitored and documented for every meal and the DON stated it should have been documented because if it was not documented it was not done. The DON confirmed the wrong diet was served to Resident 8 on 4/7/2024 and the DON stated the correct therapeutic diet should be served to the residents to prevent malnutrition. The DON stated the severe weight loss of 7.7 % in one month (March to April) and 15% weight loss in three months (January to April) was avoidable and it happened due to lack of monitoring and delayed interventions. During a review of the facility's policy and procedure titled Nutrition Status Management, revised/reviewed on 12/2023, the policy indicated the facility will assess each resident's nutritional status and needs, including medications and medical conditions to ensure that all residents maintain acceptable parameters of nutritional status, such as body weight and other available data, unless the resident's clinical condition demonstrates that it was not possible. The policy indicated: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Nutritional assessment included weighing and weight changes, oral intake of foods and fluids and nutrition prescriptions. b. The IDT will monitor and reevaluate the resident's response or lack of response of the interventions and revise or discontinue the approaches or justifying the continuation of current approaches. c. Any resident weighed that varies from the previous reporting period by 5% or 5 lbs. in 30 days, 7.5% in 90 days and 10% in 180 days will be evaluated by the interdisciplinary team to determine the cause of weight loss and gain and intervention required. d. The IDT will update and revise the care plan as appropriate. During a review of the facility's policy and procedure titled Diet Orders, 2023, the policy indicated diet orders prescribed by the physician will be provided by the Food and Nutrition Services Department.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45028 Based on observation, interview, and record review, the facility failed to provide treatment and services to maintain or prevent further decrease in joint range of motion (ROM, full movement potential of a joint) and/or mobility for four of 12 sampled residents (Resident's 11, 12, 30, and Resident 43). The facility failed to ensure that Residents 11, 12, 30 and Resident 43 received Restorative Nursing Aide (RNA, nursing aide program that helps residents maintain their function and joint mobility) treatment five times a week as ordered. This deficient practice had the potential for Resident's 11, 12, 30 and Resident 43 to have an avoidable decline in range of motion and mobility. Findings: A. During a review of Resident 11's Admission Record (Face Sheet), the Face Sheet indicated the resident was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including major depressive disorder (a mood disorder which causes a persistent feeling of sadness and loss of interest), dementia (the loss of thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life activities), osteoarthritis (tissues in the joint [part of the body where two or more bones meet to allow movements] break down over time), and muscle wasting (a weakening, shrinking, and loss of muscle caused by disease or lack of use). During a review of Resident 11's Minimum Data Set ([MDS] a standardized assessment and care-screening tool) dated 2/7/2024, the MDS indicated Resident 11's cognition (ability to make decisions of daily living) was moderately impaired and was always able to understand and be understood by others. The MDS indicated Resident 11 required substantial/maximum assistance (helper lifts or holds trunk or limbs and provides more than half the effort) from staff for toileting hygiene, showering/bathing, upper body dressing, and lower body dressing. The MDS indicated Resident 11 was totally dependent (resident does none of the effort to complete the activity) for rolling left to right in bed, sitting to lying in bed, lying to sitting on the side of the bed, toilet transfer, and for tub/shower transfer. The MDS indicated Resident 11 did not walk during the assessment period. During a review of Resident 11's untitled Care Plan, initiated on 9/22/2018, the Care Plan indicated Resident 11 was identified to have an activity of daily living (ADL) self-care performance deficit related to confusion, poor communication, gait/balance (manner of walking) problems dementia, and depression. The Care Plan goal indicated Resident 11 will maintain current level of function through the review date of 5/18/2024. The Care Plan interventions for Resident 11 included for RNA to assist with bilateral (both) upper (UE) and lower extremity (LE) exercises in all planes (moving side-to-side, front, and back, or rotationally) as tolerated five times a week. During a review of Resident 11's Order Summary Report (Physician's Orders), the Order Summary Report indicated an order was placed on 4/1/2024, for RNA to assist with bilateral upper and lower extremity exercises in all planes as tolerated every day shift, five times a week. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 11's RNA Treatment Flow Sheet dated April 2024, the RNA Treatment Flowsheet indicated the documentation section was blank on 4/1/2024, and from 4/5/2024 to 4/7/2024. The Treatment Flow Sheet Indicated RNA treatment was not completed five days a week, as ordered. B. During a review of Resident 12's Face Sheet, the Face Sheet indicated Resident 12 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including difficulty in walking, muscle weakness, major depressive disorder, and Alzheimer's disease (a brain disorder which slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks). During a review of Resident 12's History and Physical (H&P) dated 2/3/2023, the H&P indicated Resident 12 did not have the capacity to understand and make decisions. During a review of Resident 12's MDS dated [DATE], the MDS indicated Resident 12's cognition was moderately impaired, was usually understood and was usually able to understand others. The MDS indicated Resident 12 required substantial/maximum assistance from staff for toilet transfer, tub/shower transfer, toileting hygiene, and shower/bathing. The MDS indicated Resident 12 did not walk during the assessment period. During a review of Resident 12's untitled Care Plan, initiated on 2/8/2022, the Care Plan indicated Resident 12 was identified to have an ADL self-care performance deficit related to depression and Alzheimer's dementia. The Care Plan goal indicated Resident 12 will maintain current level of function through the review date of 4/14/2024. The Care Plan interventions for Resident 12 included for RNA to assist with range of motion ([ROM] activity aimed at improving movement of a specific joint) and ambulation as ordered. During a review of Resident 12's Physician's Orders, the Physician's Orders indicated an order was placed on 4/1/2024, for RNA to assist with bilateral upper and lower extremity exercises in all planes as tolerated every day shift, five times a week. During a review of Resident 12's RNA Treatment Flow Sheet dated April 2024, the RNA Treatment Flowsheet indicated the documentation section was blank on 4/1/2024, and from 4/5/2024 to 4/7/2024. The RNA Treatment Flow Sheet Indicated RNA treatment was not completed as five days a week as ordered. C. During a review of Resident 30's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses including rheumatoid arthritis (the body attacks itself and damages the joints), polyneuropathies (the simultaneous malfunction of many peripheral [away from the center of the body] nerves [carry messages to and from the brain and spinal cord] throughout the body), muscle weakness, abnormalities of gait and mobility, and abnormal posture. During a review of Resident 30's H&P dated 2/10/2024, the H&P indicated Resident 30 had the capacity to understand and make decisions. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 30's MDS dated [DATE], the MDS indicated Resident 30's cognition was intact and was always able to understand and be understood by others. The MDS indicated Resident 30 required substantial/maximum assistance from staff for rolling left to right in bed, sitting to lying in bed, and lying to sitting on the side of the bed. The MDS indicated Resident 30 was totally dependent from staff eating, oral hygiene, toileting hygiene, shower/bath, upper body dressing, and lower body dressing. The MDS indicated Resident 30 did not walk during the assessment period. The MDS further indicated Resident 30 had functional limitations in ROM on both upper extremities (shoulder, elbow, wrist, hand). During a review of Resident 30's untitled Care Plan, initiated on 2/4/2024, the Care Plan indicated Resident 30 was identified to have an ADL self-care performance deficit related to acute (sudden onset) weakness. The Care Plan goal indicated Resident 30 will maintain current level of function through the review date of 5/4/2024. The Care Plan interventions for Resident 30 included for bilateral upper extremity resting hand splints (supports the wrist and joints of the fingers and thumb to make sure they are positioned correctly) for up to two to six hours or as tolerated, with skin checks, before and after splint application five times a week. The Care Plan interventions included bilateral upper extremities (BUE) and bilateral lower extremities (BLE) exercises in all planes as tolerated five times a week. During a review of Resident 30's Physician's Orders dated 3/7/2024, the Physician's Orders indicated an order was placed for Resident 30 to have BUE and BLE active range of motion ([AAROM] movement at a given joint with a person's own effort and assistance from an external force or another person) exercises in all planes as tolerated every day shift, five times a week, Monday through Friday. During a review of Resident 30's Physician's Orders dated 3/8/2024, the Physician's Orders indicated an order was placed for Resident 30 to have bilateral upper extremity resting hand splints for up to two hours or as tolerated, with skin checks, before and after splint application, every day, five times a week Monday through Friday. During a review of Resident 30's RNA Treatment Flow Sheet dated March 2024, the RNA Treatment Flow Sheet indicated there was no documentation indicating Resident 30's hand splints, had been applied as ordered from 3/25/2024 to 3/29/2024. The RNA Treatment Flow Sheet indicated RNA treatments were not completed for five of the five days ordered. During a review of Resident 30's RNA Treatment Flow Sheet dated March 2024, the RNA Treatment Flow sheet indicated there was no documentation on that Resident 30 received BUE and BLE AAROM exercises on 3/28/2024. The RNA Treatment Flow Sheet indicated RNA treatments were not completed for one of the five days ordered. During a review of Resident 30's Physician's Orders dated 4/1/2024, the Physician's Orders indicated an order was placed for Resident 30 to have BUE and BLE AAROM exercises in all planes as tolerated every day shift, five times a week. During a review of Resident 30's Physician's Orders dated 4/1/2024, the Physician's Orders indicated an order was placed for Resident 30 to have bilateral upper extremity resting hand splints for up to two to six hours or as tolerated, with skin checks, before and after splint application, every day, five times a week. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/6/2024 with Resident 30, Resident 30 stated, I know my order is to have my hands splinted every day, but I have only had my hands splinted once this week and my arm and leg exercises have been done only once this week as well. I know both of my orders are for five times a week, but I don't know why I'm not getting my therapy. I am already having problems with my hands, I can't feed myself, and I'm afraid I'm going to get worse if I don't get my therapy, that is what I'm here for, right? During a follow-up interview on 4/7/2024 at 4:25 p.m. with Resident 30, Resident 30 stated, I didn't receive my therapy yesterday or today. I thought maybe I would get my therapy later in the day yesterday, but it never happened. Today I didn't get my therapy either. I don't know why it wasn't done. D. During a review of Resident 43's Face Sheet, the Face Sheet indicated Resident 43 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including left femur (thigh bone) fracture (broken bone), abnormalities of gait and mobility, and dementia. During a review of Resident 43's History and Physical (H&P) dated 2/22/2024, the H&P indicated Resident 43 did not have the capacity to understand and make decisions. During a review of Resident 43's MDS dated [DATE], the MDS indicated Resident 43's cognition was intact and was usually understood and was usually able to understand others. The MDS indicated Resident 43 required substantial/maximum assistance from staff for sitting to standing, chair to bed/bed to chair transfer, toilet transfer, toileting hygiene, tub/shower transfer, and shower/bathing. The MDS indicated Resident 43 could only walk 10 feet (once standing, the ability to walk 10 feet in a room, corridor, or similar space) with substantial/maximum assistance from staff during the assessment period. The MDS further indicated Resident 43 had lower extremity impairment on one side. During a review of Resident 43's untitled Care Plan, initiated on 3/20/2024, the Care Plan indicated Resident 43 was identified to have an ADL self-care performance deficit related to dementia and history of depression. The Care Plan goal indicated Resident 43 will maintain functional abilities through the review date of 6/18/2024. The Care Plan interventions for Resident 43 included for BUE and BLE ROM exercises in all planes as tolerated five times per week. During a review of Resident 43's Order Summary Report (Physician's Orders), an order was placed on 4/1/2024, for RNA to assist with BUE and BLE exercises in all planes as tolerated every day shift, five times a week. During a review of Resident 43's RNA Treatment Flow Sheet dated April 2024, the RNA Treatment Flowsheet indicated the documentation section was blank on 4/1/2024, 4/5/2024, and 4/7/2024. The RNA Treatment Flow Sheet Indicated RNA treatment was not completed for one out of the five days ordered. During an interview on 4/6/2024 at 3:50 p.m., with the Director of Rehab (DOR) the DOR stated, residents receive RNA services to maintain their ROM, and to prevent further decline. If residents are not getting RNA therapy as ordered by the physician that places the residents at risk for further decline, and contractures (a permanent tightening of the muscles, tendons [a tough band of dense fibrous connective tissue which connects muscle to bone], skin, and nearby tissues which cause the joints to shorten and become very stiff). (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on 4/7/2024 at 5:39 p.m., the DON stated if a resident doesn't receive the RNA services as ordered, the resident is at risk for further decline in mobility. The RNA was not available for interview during the period the recertification survey was conducted. During a review of the facility's RNA Job Description Dated 12/17/2021, the RNA Job Description indicated the essential duties and responsibilities include to perform RNA and rehabilitative procedures as instructed. During a review of the facility's policy and procedure, Physician's Orders, Telephone Orders and Recapitulation Process, undated indicated all physician's orders are in effect for 45 days from the date of the physician's signature unless otherwise specified.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906 Based on observation, interview and record review, the facility failed to ensure the enteral (method of supplying nutrients directly into the gastrointestinal tract) feeding administration set, and piston syringe were signed and dated per facility's policy and procedure, to prevent complications of gastrostomy tube ([G-tube] an artificial opening into the stomach to deliver medication, nutrition, and hydration) for one of one sampled residents (Resident 1). This failure had the potential for Resident 1 getting infections due to the enteral feeding set being used beyond it's use-by date. Findings: During a record review of Resident 1's Admission Record, the Admission Record indicated the resident was admitted on [DATE] then readmitted on [DATE] to the facility with diagnoses that included acute respiratory failure with hypoxia (often caused by a disease or injury that affects your breathing), pneumonia (an infection of the air sacs in one or both the lungs), hypotension (low blood pressure). During a record review of Resident 1's Minimum Data Set ([MDS] standardized assessment and care screening tool) dated 1/18/2024, the MDS indicated Resident 1 was rarely or never understood by others and was rarely or never understood. The MDS indicated Resident 1 was dependent (Helper does all the effort) for toileting hygiene, oral hygiene, dressing upper and lower, putting on and off footwear and personal hygiene. During a record review of the physician's order dated 10/16/2023, the physician's order indicated change enteral administration set with every formula (enteral feeding solution) bottle change. During an observation on 4/6/2024 at 7:46 a.m., at Resident's 1 room the enteral administration set and the piston syringe was undated and unsigned. During a concurrent observation and interview on 4/6/2024 at 8:12 a.m. with Licensed Vocational Nurse 1 (LVN) 1, LVN 1 stated that every time a nurse changes the formula they should also change the administration set and piston syringe, LVN 1 stated that since the enteral feeding administration set was not dated and signed it was not safe to say when it was changed. During an interview on 4/7/2024 at 6:10 p.m., with the Director of Nursing (DON), the DON stated LVN charge nurses are responsible to make sure on a daily basis the administration set and the piston syringe is changed to prevent any contamination or possible cause of infection. The DON stated that it should have a date and signature daily to be able to identify if it was done or not. During a record review of the facility's policy and procedure (P&P) titled Gastrostomy tube Care and management revised 12/2023, the P& P indicated clean all accessories, including syringes, after each use, the syringe will be discarded and replaced on a daily basis.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906 Based on interview and record review the facility failed to ensure: 1. The primary care physician visited Resident 37 to assess and continue admission orders from the hospital and complete a history and physical (H&P) making sure the facility provided the care needed during the stay in the facility for one of one sampled resident (Resident 37). 2. Ensure Resident 29's physician conducted a monthly visit for the month of 3/2024. This deficient practice has the potential to not provide Resident's 37 and 29 the appropriate medical interventions during their facility stay and had the potential to have issues or concerns missed which they may have wanted to discuss with their physician. Findings: 1. During a record review of Resident 37's Admission Record, the Admission Record indicated the resident was admitted on [DATE] then readmitted on [DATE] to the facility with diagnoses that included acute respiratory failure with hypoxia (often caused by a disease or injury that affects breathing) essential primary hypertension (occurs when you have abnormally high blood pressure that's not the result of a medical condition), benign prostatic hyperplasia (harmless prostate enlargement) . During a record review of Resident 37's Minimum Data Set ([MDS] standardized assessment and care screening tool) dated 3/6/2024, the MDS indicated the resident had the capacity to understand others and was able to be understood by staff. The MDS indicated Resident 37 required maximal assistance (helper does more than half the effort) from one staff for toileting hygiene, dressing, transfer, bed mobility, and supervision or touching assistance (helper provides verbal cues and /or touching/contact guard assistance) from one staff for eating. During a record review of a physician admission progress notes dated late entry 3/18/2024, physician admission progress notes indicated Resident 37 was admitted to the hospital with anemia (deficiency of healthy red blood cells in blood), pneumonia (an infection of the air sacs in one or both the lungs), and sepsis (a life-threatening complication that occurs due to an infection) and was treated with intravenous (IV-intravenous usually refers to a way of giving a drug or other substance through a needle or tube inserted into a vein) medication. During a concurrent interview and record review on 4/7/2024 at 2:30 p.m., with the Corporate Medical Records (MR) staff of Resident 37's unsigned and not done H &P, the MR stated that the H&P should be done within 72 hours of admission unless the Medical Doctor(MD) in the facility is the same one as the one from the hospital. The MR stated it is the responsibility of the medical records department to audit and make sure the physician comes and visits within the allowable timeframe. The MR stated if physician doesn't come in timely, she would inform the Director of Nursing (DON) and the DON would coordinate with the MD. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/7/2024 at 5:15 p.m., with the DON, the DON stated the MD needs to come to the facility within 72 hours of admission to evaluate the residents' condition, do H & P and sign Physician's orders (PO). The DON stated it was important to make sure the MD saw the resident in a timely manner to ensure appropriate care and services were provided to the Resident. The DON stated it was the DON's responsibility to make sure this regulation was being followed. The DON stated the H&P was missed and the Physicians orders were not signed. 2. During a review of Resident 29's Admission Record (Face Sheet), the Face Sheet indicated Resident 29 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including fracture (broken bone) of the left femur (thigh bone), osteoarthritis (the tissues in the joint [a part of the body where two or more bones meet to allow movement] break down over time), and abnormalities of gait and mobility. During a review of Resident 29's History and Physical (H&P) dated 1/30/2024, the H&P indicated Resident 29 had the capacity to understand and make decisions. During a review of Resident 29's MDS, dated [DATE], the MDS indicated Resident 29's cognition (ability to make decisions of daily living) was intact and had the ability to understand and be understood by others. The MDS indicated Resident 29 required substantial/maximum assistance from staff for shower/bathe self, and for lower body dressing. The MDS indicated Resident 29 required partial/moderate assistance from staff for toilet transfer, sit to stand, toilet hygiene and rolling left to right in bed. During an interview on 4/6/2024 at 8:41 a.m., with Resident 29, Resident 29 stated, she had not seen her doctor since I haven't seen her physician since November of last year. Resident 29 stated she had some questions about her care that she would like to discuss with him, but had not seen him. During a review of Resident 29's Physician Progress Notes, dated 2/2024, the Physician Progress notes indicated Resident 29 was seen by her physician on 2/14/2024. There was no documentation indicating Resident 29 was seen by her physician after 2/14/2024. During a review of Resident 29's Nursing Progress Notes, dated 3/2024, there was no documentation by the licensed nurses or facility staff indicating Resident 29's physician was notified of the missed monthly visit for the month of 3/2024. During an interview on 4/7/2024 at 5:39 p.m., with the DON, the DON stated all residents are required to be seen by their physician monthly, at least every 30 days. During a review of the facility's policy and procedure (P&P) titled, Documentation and Charting dated 5/2012, the P&P indicated each resident must be under the care of a licensed physician authorized to practice medicine in this state and must be seen by the physician at least every thirty (30) days. The P&P indicated physician's orders must be signed by the physician and dated when such order was signed. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of the facility's policy and procedure(P&P) titled Physician Visits revised 06/2015, the P & P indicated residents must be seen by a physician at least once every thirty (30) days for the first ninety days after admission, and at least every sixty thereafter. The initial comprehensive shall be made no later than 30 days after a resident's admission into the Skilled Nursing Facility (SNF).

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906 Based on interview and record review, the facility failed to communicate the following consultant pharmacist's recommendations in the Medication Regimen Review ([MRR] a thorough evaluation of the medication list of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) to the physician for two of twelve residents (Resident 20 and 13). The facility failed to: a. Attempt the gradual dose reduction (GDR), of Resident 20's Escitalopram (medication for depression), and b. Gradually discontinue Resident 13's Pantoprazole (medication that reduces acid in the stomach. These deficient practices had the potential to result in Resident 20 and 13's continued use of unnecessary medications which leads to adverse drug reactions and negative health outcomes for the residents. Findings: a. During a review of Resident 20's Admission Record (Face Sheet), the Face Sheet indicated Resident 20 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including diabetes mellitus (DM) a chronic disease characterized by elevated levels of blood glucose [or blood sugar] in a bloodstream), end stage renal disease (a condition in which the kidneys [one of a pair of organs in the abdomen which remove waste and extra water from the blood (as urine) and help keep chemicals balanced in the body] lose the ability to remove waste and balance fluids), and depression (a constant feeling of sadness and loss of interest, which stops a person from doing normal activities). During a review of Resident 20's Minimum Data Set ([MDS] a standardized assessment and care-screening tool) dated 1/29/2024, the MDS indicated Resident 20's cognition (ability to make decisions of daily living) was intact and had the ability to understand and be understood by others. The MDS indicated Resident 20 received antianxiety (medication used to treat symptoms of anxiety, such as feelings of fear, dread, uneasiness, and muscle tightness, which may occur as a reaction to stress) and antidepressant medication (medication used to treat depression) during the assessment period. During a review of Resident 20's Order Summary Report (Physician's Orders), the Order Summary Report indicated a physician's order dated 8/21/2023 for Escitalopram Oxalate 5 milligrams ([mg] a unit of measure of weight) give one tablet by mouth (PO) one time a day for depression manifested by verbalization of feeling depressed. (continued on next page)

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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 on 4/7/2024 at 5:39 p.m., with the Director of Nursing (DON), Resident 20's MRR dated 2/5/2024 was reviewed. The MRR indicated, Please evaluate the continuous use of Escitalopram 5 mg PO daily for depression since 8/2023. Facility must attempt a gradual dose reduction (GDR) in two separate quarters (with at least one month in between attempts), unless clinically contraindicated. Please check one of the following below to keep the facility in compliance. Upon further review, there were no checks marked to indicate whether the physician agreed or disagreed with the pharmacists' recommendation. The DON stated, she could not find any documentation that the physician was notified of, or responded to the pharmacist's recommendation for Resident 20's GDR attempt on 2/5/2024 for Escitalopram 5 mg for MRR therefore no GDR was performed for Resident 20. b. During a review of Resident 13's Admission Record, dated 4/6/2024, the admission record indicated Resident 13 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including gastroesophageal reflux disease ([GERD] occurs when stomach acid repeatedly flows back into the esophagus [tube connecting your mouth and stomach]).without esophagitis (inflammation [response to injury causing redness, swelling, pain , loss of function and heat]of esophagus), muscle weakness, abnormalities of gait and mobility, and sepsis (infection in the blood). During a review of Resident 13's MDS, dated [DATE], the MDS indicated Resident 13 had severe impairment in cognitive skills for daily decision making. The MDS indicated Resident 13 needed substantial assistance from staff, where staff does more than half the effort, with personal hygiene and eating; and Resident 13 was dependent on staff, where helper does all the effort, with oral hygiene, toilet hygiene, showering, and dressing. During a review of Resident 13's Order Summary report, as of 4/7/2024, the report indicated a physician's order dated 12/15/2023, for Pantoprazole Sodium Oral tablet delayed release 40 mg, Give one tablet by mouth (PO) in the morning for GERD. During a review of Resident 13's Note to Attending Physician/ Prescriber, printed on 2/9/2024, the note indicated the MRR for the resident was conducted on 2/5/2024. The note indicated the pharmacist left the following recommendations for Resident 13: 1. Resident 13 has been on Pantoprazole 40 mg PO every morning for GERD prophylaxis since 12/15/2023. 2. Long term proton pump inhibitor ([PPI] medicines that work by reducing the amount of stomach acid made in the lining of the stomach) was associated with many side effects such as osteoporosis/ weakening of bones (increased fall risk), increased infections such as Clostridioides difficile (germ that causes infection of the colon) and pneumonia and rebound gastric acid hypersecretion (recurrence of symptoms due to an increase in gastric acid secretion above pre-treatment levels after stopping PPI therapy). 3.Resident 13 was not on any direct acting oral anticoagulant (blood thinner) to warrant indefinite PPI gastroprotection (serving to protect the stomach from damage). 4. For the physician to evaluate if Pantoprazole can be tapered to Pantoprazole 40 mg PO once every other day for two weeks then discontinued. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. If prophylaxis (action taken to prevent disease) was necessary, for the physician to consider a different type of medication like Famotidine (medication to treat GERD) 20 mg daily for one month. The note indicated the section, Physician/ Prescriber Response was left blank. The section indicating if the physician agreed, disagreed with the pharmacist's recommendation was left blank. The section for the physician's signature and date was left blank. During a telephone interview on 4/07/2024 at 9:35 a.m. with the pharmacist, the pharmacist stated prolonged Protonix use was not recommended because of all the side effects and especially bad for the bones so Pharm D usually made recommendations to gradually discontinue the medication and recommended alternatives. During an interview and record review on 4/7/2024 at 5:39 p.m., with the DON, Resident 13's Note to Attending Physician/ Prescriber, printed 2/9/2024, was reviewed and the note indicated the MRR for the resident was conducted on 2/5/2024. The note indicated the physician portion of the note was blank. The DON stated the MRR was conducted by the pharmacist on 2/5/2024 and the note was blank because it was not given to the physician for review. The DON stated the charge nurses were responsible for relaying the pharmacists' recommendations to the physician. The DON stated if the recommendations were not relayed to the physicians, residents were at risk for consuming unnecessary medications that can be harmful for the residents. During a review of the facility's policy and procedure (P&P) titled, Medication Regimen Review and Reporting, and dated 2012, the P&P indicated the consultant pharmacist and the care center follow up on the recommendations to verify that appropriate action has been taken. The P&P indicated the recommendation shall be acted upon within a reasonable timeframe. The P&P indicated the physician may accept or act on recommendation or reject recommendation and provide an explanation for disagreement. During a review of the facility P&P, titled Consultant Pharmacist Reports, dated 11/2017, indicated the MRR was conducted to evaluate a resident's response to medication therapy to prevent or minimize adverse consequences related to medication therapy. The P&P indicated that the consultant pharmacist's recommendations are acted upon and documented by the facility staff and/or the prescriber. 45028

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F 0757 Level of Harm - Minimal harm or potential for actual harm 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** 45028 Based on interview and record review, the facility failed to ensure the licensed nurses acted upon the Pharmacists' Consultation Report by notifying Resident 20's physician about the pharmacist recommendation to attempt a gradual dose reduction of Escitalopram Oxalate (medication used to treat depression [a constant feeling of sadness and loss of interest, which stops a person from doing normal activities]) 5 milligrams ([mg] a unit of measure of weight) give one tablet by mouth (PO) one time a day for depression manifested by verbalization of feeling depressed. This deficient practice resulted in a recommended gradual dose reduction not performed for Resident 20 and had the potential to place other residents who were receiving antidepressant (medication used to treat depression) medications at risk for use of unnecessary medication. Findings: During a review of Resident 20's Admission Record (Face Sheet), the Face Sheet indicated Resident 20 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including diabetes mellitus (DM) a chronic disease characterized by elevated levels of blood glucose [or blood sugar] in a bloodstream), end stage renal disease (a condition in which the kidneys [one of a pair of organs in the abdomen which remove waste and extra water from the blood (as urine) and help keep chemicals balanced in the body] lose the ability to remove waste and balance fluids), and depression. During a review of Resident 20's Minimum Data Set ([MDS] a standardized assessment and care-screening tool) dated 1/29/2024 indicated Resident 20 cognition was intact and had the ability to understand and be understood by others. The MDS indicated Resident 20 received antianxiety (medication used to treat symptoms of anxiety, such as feelings of fear, dread, uneasiness, and muscle tightness, which may occur as a reaction to stress) and antidepressant medication during the assessment period. During a review of Resident 20's Order Summary Report (Physician's Orders), the Order Summary Report indicated an order dated 8/21/2023 for Resident 20 to receive Escitalopram Oxalate 5 mg one tablet PO one time a day for depression. During a concurrent interview and record review on 4/7/2024 at 5:39 p.m., with the Director of Nursing (DON), Resident 20's medication regimen review ([MRR] a review of all medications the patient is currently using to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy), dated 2/5/2024 was reviewed. The MRR indicated, Please evaluate the continuous use of Escitalopram 5 mg PO daily for depression since 8/2023. Facility must attempt a gradual dose reduction (GDR) in two separate quarters (with at least one month in between attempts), unless clinically contraindicated. Please check one of the following below to keep the facility in compliance. Upon further review, no checks were marked on indication of disagree or agreeance of the GDR. The DON stated, I can't find the doctor's response to the pharmacist's recommendation for Resident 20's GDR attempt on 2/5/2024 for Escitalopram 5 mg for MRR. No GDR was performed for Resident 20. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Medication Regimen Review and Reporting, and dated 2012, the P&P indicated the consultant pharmacist and the care center follow up on the recommendations to verify that appropriate action has been taken. The P&P indicated the recommendation shall be acted upon within a reasonable timeframe. The P&P indicated the physician may accept or act on recommendation or reject recommendation and provide an explanation for disagreement. During a review of the facility P&P, titled Consultant Pharmacist Reports, dated 11/2017, indicated the MRR was conducted to evaluate a resident's response to medication therapy to prevent or minimize adverse consequences related to medication therapy. The P&P indicated that the consultant pharmacist's recommendations are acted upon and documented by the facility staff and/or the prescriber.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906 Based on observation, interview and record review, the facility failed to: 1. Obtain informed consent (process by which a healthcare provider educates a resident about the risks and benefits, and alternatives of a given procedure or intervention) prior to the administration of psychotropic drugs (medication that affects brain activities associated with mental process and behavior) for one out of four sampled residents (Resident 35) as indicated in the facility's policy and procedure (P&P). 2. Do a Gradual Dose Reduction ([GDR] an attempt to decrease or discontinue psychotropic) medication after three months of starting on the psychotropic medication, unless clinically contraindicated) for two of twelve sampled residents (Resident 5 and Resident 20). These deficient practices resulted in Resident 5 receiving Lorazepam (brand name Ativan, a medication used to treat anxiety [feeling of fear, dread, and uneasiness], and Resident 20 receiving Escitalopram (brand name Lexapro, a medication used to treat depression [a constant feeling of sadness and loss of interest, which stops a person from doing normal activities]) without clinical justification for use, and Resident 35 receiving unnecessary psychotropic medication. Findings: 1. During a record review of Resident 35's Admission Record, the Admission Record indicated the resident was admitted on [DATE] then readmitted on [DATE] to the facility with diagnoses that included hyperlipidemia (an unhealthy level of fats in the blood), type 2 diabetes mellitus (a common condition that causes the level of sugar (glucose) in the blood to become too high), fracture (break) of unspecified part of neck of right femur (thigh bone), subsequent encounter for closed fracture with routine healing (occur almost exclusively as a result of a traumatic hip dislocation). During a record review of Resident 35's Minimum Data Set ([MDS] standardized assessment and care planning tool) dated 1/9/2024, the MDS indicated Resident 35 was able to be understood by others and was able to understand. The MDS indicated Resident 35 was dependent (helper does all the effort) for shower/bathe self, lower body dressing, put on and take off footwear, toileting hygiene, substantial/ maximal assistance (helper does more than half the effort) for personal hygiene and upper body dressing. The MDS also indicated no behavior symptom were present. During an observation on 4/6/2024 at 8:46 a.m., with Resident 35 in his bedroom, Resident 35 was observed calm and cooperative. No behaviors were noted. During a concurrent observation and interview on 4/7/2024 at 9:24 a.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated she was already familiar with Resident 35. CNA 2 further added that sometimes Resident 35 gets agitated when you don't explain to him what you are about to do. But Resident 35 most of the time was cooperative to familiar nurses and staff that already know how to handle Resident 35. (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 record review of the medication administration record (MAR) on 4/7/2024 at 10:36 a.m., with the Infection Preventionist Nurse (IPN), the IPN stated that Resident 35's physician's order specified to call the daughter before administering lorazepam 0.5 milligram ([mg] unit of measure of weight). During a record review of the medication administration record (MAR) for the month of 4/2024, the MAR indicated a physician's order for Lorazepam 0.5 mg by mouth every eight (8) hours as needed for agitation/ restlessness/ anxiety/combative call daughter prior to giving. During a record review of the controlled drug record for Resident 35, the record indicated Resident 35 received Lorazepam 0.5 mg on 3/27/2024 at 9:15 p.m., 3/28/24 at 4:30 p.m., 4/2/2024 at 4:43 p.m., 4/4/2024 at 3:35 p.m. and 4/6/2024 at 8:18 p.m. During a continued interview and record review on 4/7/2024 at 10:48 a.m. with the IPN, the IPN stated that she could not locate in the MAR or in the progress notes that the daughter was informed prior to administering the medication to Resident 35. The IPN stated that the informed consent was not signed and not completed for Resident 35's 0.5 mg Lorazepam, as well. The IPN stated it is the responsibility of charge nurse who got the order from the prescribing Doctor to make sure the consent was completed and signed by the Resident or responsible party (RP) prior to administering the psychotropic medication. During a record review of the informed consent, it was not signed nor dated. The informed consent form was not completed with the medication name and justification of why it is necessary for Resident 35's care and treatment. 2. During a review of Resident 5's Admission Record (Face Sheet), the Face Sheet indicated Resident 5 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including fibromyalgia (a chronic [long-lasting] disorder which causes pain and tenderness throughout the body, as well as fatigue [low or lack of energy] and trouble sleeping), diabetes mellitus (DM) a chronic disease characterized by elevated levels of blood glucose [or blood sugar] in a bloodstream) type 2, and anxiety disorder. During a review of Resident 5's History and Physical (H&P) dated 7/2/2021, the H&P indicated Resident 5 has the capacity to understand and make decisions. During a review of Resident 5's MDS dated [DATE], the MDS indicated Resident 5's cognition (ability to make decisions of daily living) was intact and had the ability to understand and be understood by others. The MDS indicated Resident 5 received antianxiety (medication used to treat symptoms of anxiety, such as feelings of fear, dread, uneasiness, and muscle tightness, which may occur as a reaction to stress), opioids (powerful pain-reducing medications), and hypoglycemic medication (used to lower the level of glucose [blood sugar in the blood]) during the assessment period). During a review of Resident 5's Order Summary Report (Physician's Orders), the Order Summary Report indicated an order dated 6/30/2021 for Ativan 0.5 mg one tablet by mouth every 12 hours for anxiety as manifested by overly concern of health affecting day to day activities. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2a. During a review of Resident 20's Admission Record (Face Sheet), the Face Sheet indicated Resident 20 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including diabetes mellitus, end stage renal disease (a condition in which the kidneys [one of a pair of organs in the abdomen which remove waste and extra water from the blood (as urine) and help keep chemicals balanced in the body] lose the ability to remove waste and balance fluids), and depression (a constant feeling of sadness and loss of interest, which stops a person from doing normal activities). During a review of Resident 20's MDS dated [DATE], the MDS indicated Resident 20's cognition was intact and had the ability to understand and be understood by others. The MDS indicated Resident 20 received antianxiety (medication used to treat symptoms of anxiety, such as feelings of fear, dread, uneasiness, and muscle tightness, which may occur as a reaction to stress) and antidepressant medication (medication used to treat depression) during the assessment period. During a review of Resident 20's Order Summary Report, the Order Summary Report indicated an order dated 8/21/2023 for Escitalopram Oxalate 5 mg one tablet by mouth (PO) one time a day for depression manifested by verbalization of feeling depressed. During a concurrent interview and record review on 4/7/2024 at 5:39 p.m., with the Director of Nursing (DON), the facility's Psychotropic and Sedative (a medication taken for its calming or sleep-inducing effect)/Hypnotic (medications used which are intended to promote or improve sleep) Utilization by Resident dated 2/1/2024 to 2/9/2024 was reviewed. The Psychotropic and Sedative/Hypnotic Utilization indicated, The following is a comprehensive list of all psychotropic and hypnotic orders for each resident. The next evaluation field is the pharmacist's recommendation for the next formal assessment of the particular order. Upon further review, The Psychotropic and Sedative/Hypnotic Utilization indicated, there was no documentation when the last GDR was done for Resident 5. The DON stated, she did not know when Resident 5 had her last GDR and based on the documentation, Resident 5 never had a GDR since it was ordered on 6/30/3021. During a continued interview and record review on 4/7/2024 at 5:50 p.m., with the DON, Resident 20's Medication Regimen Review ([MRR] a review of all medications the patient is currently using to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy), dated 2/5/2024 was reviewed. The MRR indicated, Please evaluate the continuous use of Escitalopram 5 mg PO daily for depression since 8/2023. Facility must attempt a gradual dose reduction (GDR) in two separate quarters (with at least one month in between attempts), unless clinically contraindicated. Please check one of the following below to keep the facility in compliance. Upon further review, no checks were marked on indication of disagree or agreeance of the GDR. The DON stated she could not find the doctor's response to the pharmacist's recommendation for Resident 20's GDR attempt on 2/5/2024 for Escitalopram 5 mg for MRR. The DON stated that no GDR was performed for Resident 20 During an interview and record review of Resident's 35 medical record for the psychotropic medication with the DON on 4/7/2024 at 6:00 p.m., the DON stated she could not believe that the nurses are administering medication without the consent and not calling the daughter since it specifically indicated on the physician's order. DON stated that consent needs to be completed prior to administering medication since the family might not agree to any psychotropic medications, it is the responsibility of the charge nurse to inform the daughter prior to administering the medication. (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 review of the facility's policy and procedure (P&P) titled, Psychotropic Medications, revised 12/2023 the P&P indicated, It is the policy of this facility to ensure that residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record. Based on a comprehensive assessment, the facility will ensure that residents who use psychotropic drugs receive GDRs, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. The facility's Interdisciplinary Team (IDT) will review to ensure informed consent was obtained prior to medication use, and attempt/consider a GDR, if appropriate. During a record review of the facility's P&P titled use of chemical restraints revised 05/2014, the P& P indicated no chemical restraint will be utilized without specific physician's order or without a specific consent or without a diagnosed specific condition. 45028

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45028 Based on observation, interview and record review, the facility failed to: 1. Ensure monitoring of the medication refrigerator temperature on 4/5/2024 was done per the facility's policy and procedure (P&P) titled, Storage of Medication. This deficient practice had the potential for exposure of the medication to extreme temperatures potentially leading to loss of strength of the medications, causing residents to receive ineffective medication dosages. 2. Ensure Resident 52's one opened Insulin Glargine -Yfgn (brand name Semglee Pen, a medication used to control the level of sugar [glucose] in the blood) and one opened Insulin Lispro Kwikpen (brand name Humalog Kwikpen, a medication used to control the level of sugar in the blood) stored in the medication refrigerator was labeled with an open date per the facility's policy and procedure (P&P) titled, Medications with Special Expiration Date Requirements. This deficient practice of failing to label medications per the manufacturers' requirements and the facility's P&P increased the risk of Resident 52 to have received medication that had become ineffective or toxic due to improper labeling possibly leading to health complications resulting in hospitalization or death. 3. Properly label a multi-dose vial of Tuberculin (brand name Aplisol, a medication used in a skin test (injecting medication into the surface layer of the skin which is measured after 48 to 72 hours) to help diagnose tuberculosis [TB, a potentially serious infectious bacterial disease which mainly affects the lungs]) with an open date per the facility's P&P titled, Medications with Special Expiration Date Requirements. These deficient practices of failing to label medications per the manufacturers' requirements and the facility's P&P increased the risk of all residents receiving medication that had become ineffective or toxic due to improper labeling possibly leading to health complications resulting in hospitalization . 1. During a concurrent interview and record review on 4/6/2024, at 11:19 a.m., with the Licensed Vocational Nurse (LVN) 2, the medication refrigerator Temperature Monitoring Record dated 2/2024 was reviewed. The Temperature Monitoring Record indicated there was no documentation indicating the refrigerator temperature was checked on 4/5/2024. LVN 2 stated that the licensed nurses are responsible for monitoring the refrigerator temperature every day. LVN 2 stated that if the licensed nurses don't check the refrigerator temperature every day, they might not know if the temperature was out of range for the medications which are required to be stored in the refrigerator. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Storage of Medication, dated 2012, the P&P indicated, medications requiring refrigeration or temperatures between 2 Centigrade ([C]a unit of measure of temperature) (36 Fahrenheit [F] a unit of measure of temperature) and 8 C (46 F) are kept in a refrigerator with a thermometer to allow temperature monitoring. 2. During a review of Resident 52's Admission Record (Face Sheet), the Face Sheet indicated Resident 52 was originally admitted to the facility on [DATE] with metabolic encephalopathy (disturbance of brain function), diabetes mellitus ([DM] a chronic disease characterized by elevated levels of blood glucose [or blood sugar] in a bloodstream) type 2, and seizures (sudden, uncontrolled body movements and changes in behavior which occur because of abnormal electrical activity in the brain). During a review of Resident 52's History and Physical (H&P) dated 4/2/2024, the H&P indicated Resident 52 had the capacity to understand and make decisions. During a review of Resident 52's Minimum Data Set ([MDS] standardized assessment and care-screening tool) dated 4/1/2024 , the MDS indicated Resident 52's cognition (ability to make decisions of daily living) was intact and had the ability to be understood and understand others. The MDS indicated Resident 52 received hypoglycemic (medications used to lower blood sugar) medication during the assessment period. During a concurrent observation and interview on 4/6/2024 at 11:24 a.m., of Station 1's medication refrigerator, with LVN 2, the following medications were found not labeled with an opened date: 1. One Insulin Glargine -Yfgn for Resident 52 was found open but not labeled with an open date. 2. One Insulin Lispro Kwikpen for Resident 52 was found open but not labeled with an open date. According to the manufacturer's product labeling, once opened, Insulin Glargine - Yfgn and Insulin Lispro Kwikpen may be stored in a refrigerator up to 28 days. LVN 2 stated the Insulin Glargine - Yfgn and Insulin Lispro Kwikpen for Resident 52 are opened and not labeled with an open date. LVN 2 stated that Glargine - Yfgn and Insulin Lispro Kwikpen need to be labeled with an open date once opened so the licensed nurses know when they'll expire. LVN 2 stated administering expired medications to residents could cause clinical complications which could possibly result in hospitalization . During a review of the facility's P&P titled, Medications with Special Expiration Date Requirements, dated 2012, the P&P indicated medications should include the date of opening on the container/vial. 3. During a concurrent observation and interview on 4/6/2024 at 11:36 a.m., with the Licensed Vocational Nurse (LVN 2), one multi-dose vial of Tuberculin was found open but not labeled with an expiration date. According to the manufacturer's product labeling, once opened, Tuberculin must be stored in the refrigerator for up to 30 days. LVN 2 stated, Tuberculin needs to be labeled with an open date once the vial is opened so the licensed nurses know when it expires. Administering expired medications to residents could cause clinical complications which could potentially result in hospitalization . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/7/2024 at 5:39 p.m., with the Director of Nursing (DON), the DON stated, that when the licensed nurses open a new multi-dose medication, they must document the open date and an expiration date on the medication. If there is no opened date on the medication, there is no way for the licensed nurses to know when the open or expiration date is and potentially administer expired medication to the residents which could result in a change in condition and unnecessary hospitalization . During a review of the facility's P&P titled, Medications with Special Expiration Date Requirements, dated 2012, the P&P indicated medications should include the date of opening on the container/vial.

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on interview and record review the facility failed to ensure the computed tomography scan ([CT] imaging tests to detect internal injuries and disease) with intravenous contrast (to administer materials directly to the person's vein to enhance the images of the test), ordered on 3/14/2024, to rule out Clostridioides difficile (germ that causes infection of the colon) / Colitis relapse diagnosis with diarrhea (loose watery stools) for one of one resident (Resident 48) was completed. The deficient practice had the potential to result in an undiagnosed problem which could have placed Resident 48 at higher risk for physical decline. Findings: During a review of Resident 48's Admission Record, dated 4/6/2024, the admission record indicated Resident 48 was admitted to the facility on [DATE] with diagnoses including infectious gastroenteritis (an inflammation [response to injury causing redness, swelling, pain, loss of function and heat]of the lining of the stomach and intestines) and colitis (disease characterized by inflammation of the inner lining of the colon) and cystitis (infection of the bladder [organ that holds the urine]) without hematuria (blood in the urine). During a review of Resident 48's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 3/7/2024, the MDS indicated Resident 48 had moderate impairment in cognitive (thinking reasoning, remembering) skills for daily decision making. The MDS indicated Resident 48 needed set-up or clean up assistance with eating and oral hygiene, supervision with toileting and upper body dressing, and partial assist when helper does less than half the task with showering, lower body dressing, and personal hygiene. During a review of Resident 48's Order Summary report, as of 4/6/2024, the report indicated a physician's order dated 3/14/2024, for a CT with intravenous contrast to rule out Clostridioides difficile / Colitis relapse diagnosis with diarrhea. During an interview and record review on 4/7/2024 at 3:26 p.m., with Licensed Vocational Nurse 1 (LVN 1), Resident 48's order for CT scan was reviewed. LVN 1 stated routine orders should be completed in twenty-four hours or as soon as reasonably possible. During an interview and record review on 4/7/2024 at 3:30 p.m., with LVN 1, Resident 48's medical records were reviewed and there was no documented evidence the CT scan with IV contrast was completed. LVN 1 stated the CT scan should have been completed to see if Resident 48 had colitis or any acute (severe and sudden onset) problems. During an interview and record review on 4/7/2024 at 5:39 p.m., with the Director of Nursing (DON), the DON stated if a CT scan was ordered then it should have been done to rule out any acute injuries or diseases. (continued on next page)

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	056104	A. Building B. Wing	04/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Villa Health Care Center	9028 Rose Street Bellflower, CA 90706

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled X-Ray/ EKG/US/ ECHO, undated, the policy indicated upon receiving an order for X-Ray, Ultrasound or Echocardiogram, either from the facility or the attending physician, a mobile unit will be dispatched to the facility. During a review of the facility's Facility Assessment Tool, Updated 8/10/2023, the tool indicated if the resident care would be provided using clinical resources available. The tool indicated radiology services were provided through contractual agreements for both routine and stat radiology needs.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906 Based on observation, interview, and record review the facility failed to ensure Resident 8 received the ordered Consistent Carbohydrate Diet (CCHO, diet with the same amount of carbohydrates [sugars], main nutrients in our diet, every day), regular texture, thin liquids consistency, fortified (extra nutrients added), with chopped meat, on 4/7/2024. This deficient practice placed Resident 8 at higher risk for continued severe weight loss (weight loss greater than 5 percent in one month and greater than 7.5 percent in three months) and at higher risk for malnutrition (body does not get enough nutrients). Findings: During a review of Resident 8's Admission record, dated 4/6/2024, the admission record indicated Resident 8 was initially admitted to the facility on [DATE] and recently readmitted to the facility on [DATE] with a diagnoses including sepsis (infection of the blood), muscle weakness, dysphagia (difficulty swallowing), mild calorie protein-calorie malnutrition (nutritional status in which reduced availability of nutrients leads to changes in body composition and functions), schizophrenia (mental illness that affects how a person thinks, feels and behaves), diabetes mellitus (disorder where the body cannot regulate glucose or sugar like it should), and dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). During a review of Resident 8's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 3/7/2024, the MDS indicated Resident 8 had severe impairment in cognitive (thinking reasoning, remembering) skills for daily decision making. The MDS indicated Resident 8 needed set up assistance with eating, supervision with personal hygiene, and substantial assistance from staff, where staff does more than half the effort, with oral hygiene. The MDS indicated Resident 8 was 64 inches in height and last weighed 104 pounds (lbs.) and the resident had a weight loss of 5 percent or more in the last month. During a review of Resident 8's Order Summary report, as of 4/7/2024, the Order Summary report indicated an order dated 2/17/2024, for CCHO diet regular texture, thin liquids consistency, fortified, with chopped meat. During a review of an untitled care plan, initiated on 12/18/2023, the care plan indicated Resident 8 had a nutritional problem or potential nutritional problem. The care plan indicated the resident would maintain adequate nutritional status as evidenced by maintaining weight greater than 104 lbs. with no signs and symptoms of malnutrition. The care plan interventions, initiated on 3/5/2024, indicated to provide diet as ordered by the physician. During a concurrent observation and interview on 4/7/2024, at 8:33 a.m., with Registered Dietician 1(RD) 1, in Resident 8's room, Resident 8 was observed eating breakfast without a salt packet on her breakfast tray and the diet profile card indicated Resident 8's diet was CCHO no added salt (NAS) Regular, chopped meat, fortified. RD 1 stated Resident 8's diet profile card, food tray, and the order did not match and Resident 8 should have had a salt packet with the her breakfast tray. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Dietary Supervisor (DS) on 4/07/2024 at 7:57 p.m., the DS stated Resident 8 was served the incorrect order. The DS stated the correct diet should be served to residents to prevent malnutrition. During an interview with the Director of Nursing (DON) on 4/7/2024 at 8:00 p.m., the DON confirmed the wrong diet was served to Resident 8 on 4/7/2024 and the DON stated the correct therapeutic diet should be served to residents to prevent malnutrition. During a review of the facility's policy and procedure titled Diet Orders, 2023, the policy indicated diet orders prescribed by the physician will be provided by the Food and Nutrition Services Department.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 43906 Based on interview and record review, the facility's Quality Assessment and Assurance ([QAA] to develop and implement appropriate plans of action to correct identified quality deficiencies) and Quality Assurance Performance Improvement ([QAPI] designated to bring about constant and measurable improvement in the services provided at the facility for continual improvement of quality care) committee failed to ensure the facility's administrator attended the monthly meetings. This deficient practice has a potential for the QAA committee not to identify and not to respond to systemic problems to improve services for the residents. Findings: During the entrance conference on 4/6/2024 at 10:46 a.m. with the Director of Nursing (DON), the DON stated that they do the monthly QAPI meeting to identify the concerns of residents', to improve the services and care of the residents in the facility. During a concurrent interview and record review of the QAA meeting minutes for the month 3/2024 on 4/7/2024 at 6:00p.m., with the Director of Nursing (DON), the DON stated that the admin is present during the meeting, but the administrator did not sign the attendance sheet. The DON stated that anybody that is present during the meeting should sign in to indicate they are physically present in the meeting. Neither the Infection Preventionist (IP), nor the DON signed the attendance sheet. During a record review of the facility's 2024 Quality Assurance and Performance Improvement (QAPI) Plan, it indicated the Administrator, and the QA Committee of the governing body have the responsibility for integrating the QAPI plan. The Administrator is responsible for direct oversight for all functions of the QAPI committee and reports directly to the governing body. The Administrator has received training on QAPI and used the Centers for Medicare and Medicaid Services (CMS), American Health Care Association (AHCA), Health Services Advisory Group(HSAG) websites for research. The Facility Administrator has the ultimate responsibility for the QAPI plan. The Administrator must make sure there is a plan in place and that all department heads are aware of their individual responsibilities according to the plan.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906 Based on interview and record review the facility failed to offer the influenza (Flu-an infection of the nose, throat and lungs, which are part of the respiratory system) vaccine and pneumococcal vaccine (vaccine that helps prevent pneumonia, an infection that inflames the air sacs in one or both lungs) to two of six sampled residents (Resident 1 and Resident 104). This failure had the potential to result in Residents 1 and 104 acquiring and transmitting the flu and pneumonia to other residents, staff, and visitors. Findings: During a record review of Resident 1's Admission Record, the Admission Record indicated the resident was admitted on [DATE] then readmitted on [DATE] to the facility with diagnoses that included acute respiratory failure with hypoxia (often caused by a disease or injury that affects breathing) pneumonia (an infection of the air sacs in one or both the lungs), hypotension (low blood pressure). During a record review of Resident 1's Minimum Data Set ([MDS] standardized screening tool) dated 1/18/2024, the MDS indicated Resident 1 was rarely or never understood by others and was rarely or never been understood. The MDS indicated Resident 1 was dependent (Helper does all the effort) for toileting hygiene, oral hygiene, dressing upper and lower, putting on and off footwear and personal hygiene. During a record review of the immunization (fortifying the body against infections) tab record for Resident 1, the immunization record did not indicate that Resident 1 received the flu and pneumococcal vaccinations. During a review of Resident 104's Admission Record, the Admission Record indicated the resident was admitted on [DATE] to the facility with diagnoses that included hypertension (high blood pressure), falls and spinal stenosis (when the space inside the backbone is too small). During a record review of the History and Physical (H&P) dated 4/2/2024, the H&P did not indicate whether resident has the capacity to make decisions. During a record review of the resident consent for influenza, pneumococcal and covid-19 (a severe infection that is easily transmittable) vaccination dated 4/1/2024, the consent indicated that that Resident 104 agreed to receive the influenza, pneumococcal and covid-19 vaccines. During a concurrent interview and record review of the immunization records of Resident 104 and Resident 1 with the Infection Preventionist Nurse (IPN) on 4/6/2024 at 4:35 p.m., the IPN stated Resident 104 signed the consent on 4/1/2024 for all three vaccines (Influenza, Pneumonia and Covid vaccine) but it was never administered. The IPN stated she did not think she was allowed to administer the flu vaccine during the non-flu season. The IPN further added for Resident 1 she did not know who would give the consent since Resident 1 did not have a responsible party, so she never offered any the vaccinations to her. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 1's Initial Interdisciplinary Team (IDT- resident's health care team consisting of various specialties) conference dated 10/17/2023 under immunizations and consents, the record indicated reviewed with case worker and obtained verbal consent. During a continued interview and record review of the immunization records for Resident 1 and Resident 104 with the IPN on 4/7/2024 at 4:58 p.m., the IPN stated she should have administered both the flu and pneumonia vaccines since Resident 1 and Resident 104 were at risk for getting the flu and pneumonia and they are both elderly and had multiple medical condition that make them vulnerable to infections. The IPN stated that the flu vaccine and pneumonia vaccine is a good protection against the flu and pneumonia. During an interview with the Director of Nursing (DON) on 4/7/2024 at 6:01 p.m., the DON stated that it was the responsibility of the IPN to make sure all the vaccines was offered to all eligible staff and residents in the facility. The DON stated that if the consent is signed, the IPN has 72 hours to administer the vaccines. The DON stated if it is not documented it is not done. During a record review of the facility's policy and procedure (P&P) revised 7/2023, titled Immunizations-Resident, the P&P indicated the facility will offer and administer flu and pneumococcal immunization to eligible residents after providing education on the risks and potential side effects of the vaccine and obtaining consent, eligibility to receive may include, but it is not to current vaccine status, season/time of the year, medical contra indications or resident preference/choice. If the resident was admitted outside the influenza season, the facility is not expected to offer the vaccine to the resident and will be handled on a case-by-case basis depending on individual needs and preferences along with the physician recommendations.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906 Based on interview and record review the facility failed to ensure that Resident 104 received the covid-19 (an disease caused by a virus, which is characterized mainly by fever and cough and can progress to severe symptoms and in some cases death, especially in older people and those with underlying health conditions) vaccination. This deficient practice placed Resident 104 at risk of acquiring serious infections such as pneumonia and covid-19 that could result in serious symptoms. Findings: During a record review of Resident 104's Admission Record, the Admission Record indicated the resident was admitted on [DATE] to the facility with diagnoses that included hypertension (high blood pressure), falls and spinal stenosis (happens when the space inside the backbone is too small). During a review of the History and Physical (H&P) dated 4/2/2024, the H&P did not indicate if Resident 104 had the capacity to make decisions. During a concurrent interview and record review of the immunization (administered resistance to an infection) record of Resident 104 with the Infection Preventionist Nurse (IPN), the IPN stated Resident 104 signed the consent on 4/1/2024 for the Covid vaccine, but it was never administered. The IPN stated that she has not had a chance to administer the vaccination yet, but she was aware that the consent was signed on 4/1/2024. The IPN stated that vaccines are protection against infectious disease, and Resident 104 is vulnerable and elderly so she is at risk for getting the virus if not vaccinated. During a record review of the resident consent for covid-19 vaccination dated 4/1/2024, the consent indicated that that Resident 104 agreed to receive the covid-19 vaccine. During an interview with the Director of Nursing(DON) on 4/7/2024 at 6:01 p.m., the DON stated that it is the responsibility of the IPN to make sure all the vaccines were offered to all eligible staff and residents in the facility. The DON stated that from the day the consent is signed, the IPN has 72 hours to administer the vaccine. The DON stated if it is not documented it is not done. During a record review of the facility's policy and procedure (P&P) revised 7/2023, titled Immunizations-Resident, the P&P indicated the facility will offer and administer flu, pneumococcal and Covid-19 immunization to eligible residents after providing education on the risks and potential side effects of the vaccine and obtaining consent, eligibility to receive may include, but it is not to current vaccine status, season/time of the year, medical contra indications or resident preference/choice. The P&P indicated each resident is offered a covid-19 immunization unless the immunization is contraindicated or the resident has already been immunized, document administration details in the residents medical record if administered.