STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056110	A. Building B. Wing	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laguna Hills Health and Rehabilitation Center	24452 Health Center Drive Laguna Hills, CA 92653

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43119 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide reasonable accommodations to meet the needs for three sampled residents (Residents 13, 22, and 166) and three nonsampled residents (Residents 50, 77, and 109). * The facility failed to ensure Residents 50 and 77 were provided with assistance in a timely manner. * The facility failed to ensure Residents 109 and 166's call lights were answered in a timely manner. * The facility failed to ensure Residents 13, 22, and 50's call lights were within the resident's reach. These failures had the potential to negatively impact the residents' psychosocial well-being or result in a delay to provide care. Findings: Review of the facility's P&P titled Call Light revised 1/2024 showed the purpose of this procedure is to ensure the timely responses to the resident's requests and needs. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. The P&P further showed upon admission and as needed, resident call light shall be within reach. (will move this statement under findings when all the HFENs have written their tags) The facility's call light P&P also showed each resident is provided with a means to call staff directly for assistance from his/ her bed, from toileting/bathing facilities and from the floor. Call system communication may be audible or visual. The system be wired or wireless. The resident call system remains functional at all times. If audible communication is used, the volume is maintained at an audible level that can be easily heard. If visual communication is used, the lights remain functional. The resident call system is routinely maintained and tested by the maintenance department. The purpose of this procedure is to ensure timely responses to the resident's requests and needs. 1. On 8/13/24 at 1010 hours, review of the Resident Council minutes for three consecutive months: 6/10, 7/8, and 8/12/24, showed the call lights were concerns. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/13/24 at 1049 hours, an observation and concurrent interview was conducted with multiple residents during the Resident Council meeting. When asked about the response time for the call lights, Residents 50, 77, and 109's call lights were not answered timely, staff were not deployed properly, and there were staff shortage. On 8/14/24 at 1043 hours, an observation and concurrent interview was conducted with Resident 50. When asked about the response time for the call lights, Resident 50 stated the call light response time was depended on who the staff was and how many residents he/she had. Resident 50 described a time when she waited for 40 minutes before the afternoon shift staff assisted her from the bathroom back to her bed. Resident 50 stated she needed assistance from the bathroom to get back to her bed. Resident 50 stated she knew she waited that long because she kept track of the time on her cell phone. Resident 50 stated she used to feel upset and frustrated but did not anymore because she knew the staff were busy. Medical record review for Resident 50 was initiated on 8/14/24. Resident 50 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 50's MDS dated [DATE], showed Resident 50 was cognitively intact. Review of Resident 50's plan of care showed the care plan intervention included an extensive assistance with one person assistance with toilet use, bed mobility, personal hygiene, oral care, dressing, and transfer. Resident 50 required total assistance with one person assistance with bathing. 2. On 8/14/24 at 1023 hours, an observation and concurrent interview was conducted with Resident 77. When asked about the response time for the call lights, Resident 77 described a time when he waited for an hour and a half before the night shift staff changed his soiled incontinence brief. Resident 77 stated he knew he waited that long because he looked at the clock. Resident 77 stated he felt not too good because it got to a point when the bed sheet got wet, and he had to wait until the morning to had it change. Medical record review for Resident 77 was initiated on 8/14/24. Resident 77 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 77's MDS dated [DATE], showed Resident 77 was cognitively intact. Review of Resident 77's plan of care showed the care plan interventions included an extensive assistance with one person assistance with toilet use, bed mobility, personal hygiene, oral care, dressing, and transfer. Resident 77 required total assistance with one person assistance with bathing. On 8/19/24 at 1604 hours, the DON was informed and acknowledged above findings. 39670 3. Medical record review for Resident 109 was initiated on 8/14/24. Resident 109 was admitted to the facility on [DATE]. Review of Resident 109's MDS dated [DATE], showed Resident 109 had intact cognition. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/24 at 0913 hours, an interview was conducted with Resident 109. Resident 109 stated she had a concern about the facility staff not answering her call light on time. Resident 109 stated she needed to wait 20 minutes when she needed an assistance in going to the bathroom. Resident 109 stated she looked at her personal cellphone for the time when she was waiting for the nurse's assistance. Resident 109 stated she had an incontinent episode for bowel and bladder while waiting for assistance. Resident 109 stated she was wearing a disposable brief at night because she did not want to dirty herself. Resident 109 stated she felt ashamed and neglected in the facility. On 8/19/24 at 1526 hours, an interview for Resident 109 was conducted with CNA 5. CNA 5 stated Resident 109 was able to make her needs known to staff and was able to use the call light. CNA 5 stated Resident 109 was able to use the bathroom using her wheelchair. CNA 5 verified Resident 109 was using disposable briefs at night. On 8/19/24 at 1630 hours, an interview was conducted with the DON. The DON was informed and verified the above findings. 39683 4. Medical record review for Resident 166 was initiated on 8/12/24. Resident 166 was admitted to the facility on [DATE]. Review of Resident 166's H&P examination dated 7/25/24, showed Resident 166 had mental capacity. On 8/13/24 at 1752 hours, an interview was conducted with Resident 166 and Family Member 1. Resident 166 stated call-light response time was horrible. Family Member 1 stated it frequently took from 30 minutes to an hour for staff to respond to the call light. Family Member 1 stated one time, it took so long waiting for a staff to respond to the call light and assist Resident 166 to the bathroom, and the resident had an accident in their bed. Family Member 1 stated the staff still had not responded to the call light, so they ended up cleaning up and changing the resident. Family Member 1 stated the family frequently stayed with Resident 166, even overnight, and now if it took too long for staff to respond, they usually assisted the resident themselves to the restroom without staff's assistance. Resident 166 stated he did not like having to wait so long for assistance. 47474 5. Medical record review for Resident 22 was initiated on 8/12/24. Resident 22 was admitted to the facility on [DATE], and was readmitted on [DATE]. Review of Resident 22's annual MDS dated [DATE], showed Resident 22 had a BIMS score of 12 which meant the resident's cognition was moderately impaired. On 8/12/24 at 0820 hours, an observation and concurrent interview with CNA 10 was conducted in Resident 22's room. Resident 22 was observed in bed with call light on top of the resident's bedside drawer, adjacent to the resident's bed and not within reach. CNA 10 verified Resident 22's call light was on top of the bedside drawer and not within reach. CNA 10 stated call lights were kept within reach to ensure the resident's safety and allow residents to communicate to staff. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/19/24 at 1350 hours, an interview with the Administrator and DON was conducted. The Administrator and DON acknowledged the above findings. 39453 6. On 8/13/24 at 0806 hours, Resident 13 was observed lying in bed. A thick blanket was observed on the resident, up to his chest. A bedside table was observed in front of the resident. The call light cord can be seen thru the blanket, but the call light button was underneath the bedside table. Resident 13 stated he had pain on his feet. When asked to press his call light, Resident 13 tried to pull the cord but could not get and reach the call light button underneath the bedside table. There was no staff observed in the hallway. On 8/13/24 at 0815 hours, CNA 13 was asked to go to Resident 13's room. The bedside table was observed slightly turned towards the left side of the bed. The call light cord could be seen thru the blanket, but the blanket was folded over the call light button on the resident's lap. Resident 13's call light button was not within the resident's reach. CNA 13 verified the findings. CNA 13 stated Resident 13 could use the call light. Medical record review for Resident 13 was initiated on 8/12/24. Resident 13 was admitted to the facility on [DATE]. Review of Resident 13's MDS dated [DATE], showed Resident 13 had severe cognitive impairment, and the resident required partial/moderate assistance from staff for mobility. On 8/19/24 at 1046 hours, an interview was conducted with the DSD. When asked about the call light, the DSD stated the staf had to ensure the call light was within the resident's reach.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39856 Based on interviews, medical record review, and facility P&P review, the facility failed to ensure the physician and resident's responsible party were notified of the significant unplanned weight loss for one of 35 final sampled residents (Resident 25). This failure resulted in a delay in the communication of Resident 25's significant unplanned weight to the physician and responsible party, which had the potential to negatively impact the resident's well-being. Findings: Review of the facility's P&P titled Weight Management Standard updated May 2023 showed in part, Practice: evaluate residents with significant weight changes to ensure timely intervention by the facility interdisciplinary team to determine and achieve best possible clinical outcomes . MD and RP (responsible party) notification: Nursing: Complete SBAR/COC significant weight changes 5% in one month, 10% in six months. MD and RP notified. Medical record review for Resident 25 was initiated on 8/15/24. Resident 25 was admitted to the facility on [DATE], and readmitted from the acute care hospital on 6/17/24. Review of Resident 25's weight and vital signs summary showed the following: - on 5/14/24, an admission weight of 118 lbs., - on 6/10/24, a weight of 116 lbs., - on 6/18/24, a readmission weight of 110 lbs, 8 lbs or 6.7% weight loss since 5/14/24. On 8/19/24 at 0843 hours, an interview and concurrent medical record review for Resident 25 was conducted with the ADON. The ADON verified the physician was not notified of Resident 25's significant unplanned weight loss upon readmission on 6/17/24. On 8/19/24 at 0912 hours, an interview and concurrent medical record review for Resident 25 was conducted with the DON. The DON verified Resident 25 experienced an unplanned significant weight loss upon readmission from the acute care hospital on 6/18/24. The DON stated the nursing staff was responsible to complete a change of condition assessment or progress note regarding significant unplanned weight loss. The DON added the physician and RP should be notified of any change in condition including unplanned significant weight loss. The DON verified Resident 25's family member was her RP. The DON was unable to find documentation the physician and RP were notified of the significant unplanned weight loss upon readmission from the hospital.

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683 Based on observation, interview, and facility P&P review, the facility failed to ensure a clean homelike environment for two of 35 final sampled residents (Residents 87 and 127). * Resident 127's room, Room A, had a piece of missing floor trim and cracked and missing drywall. * The facility failed to ensure Resident 87's curtains were free of dark red stains. These failures had the potential to negatively impact the residents' well-being. Findings: 1. Review of the facility's P&P titled Maintenance Service revised December 2019 showed the maintenance department is responsible for maintaining the building is in a safe manner at all times. On 8/12/24 at 0826 hours, Resident 127 was observed in Room A lying in bed. On the resident's right side of the bed was a sliding glass door and next to the door, vinyl trim at the bottom of the wall was observed with a missing piece of vinyl exposing broken and crumbled drywall. Small particles of debris were observed on the floor next to the exposed damaged drywall. On 8/12/24 at 1613 hours, the missing trim and exposed crumbled drywall were still observed in Room A; however, the debris on the floor had been removed. On 8/12/24 at 1619 hours, an interview and observation was conducted with RN 3. RN 3 observed the missing vinyl trim and damaged dry wall and stated it should not be like that. The missing vinyl area measured 13 inches wide and approximately 5 inches high (length). On 8/13/24 at 1422 hours, an interview and observation was conducted with the Maintenance Director. The Maintenance Director stated they were not previously informed of the damage prior to yesterday afternoon. The Maintenance Director stated when they went to replace the missing vinyl piece, the original vinyl piece was not found in the resident's room. 47474 2. Medical record review for Resident 87 was initiated on 8/12/24. Resident 87 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 87's significant change MDS dated [DATE], showed Resident 87 had a BIMS score of 6 which meant the resident's cognition was severely impaired. On 8/12/24 at 1008 hours, an observation and concurrent interview with CNA 8 was conducted in Resident 87's room. CNA 8 verified of Resident 87's curtain had three large, dark red streak stains located at either side of the curtain. CNA 8 stated she observed the large, dark red streak stains on the curtains in the morning; however could not identify the type of stain. (continued on next page)

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	On 8/14/24 at 1043 hours, an observation and concurrent interview with the IP was conducted in Resident 32's room. The IP verified Resident 32's curtains was observed with three large, dark red streak stains. The IP stated the dark red streak stains could be blood, feces, nail polish, and berries. The IP further stated the curtains should had been cleaned to maintain infection control. On 8/19/24 at 0952 hours, an interview with the Housekeeping and Laundry Supervisor was conducted. The Housekeeping and Laundry Supervisor stated the curtains were washed monthly and as needed. The Housekeeping and Laundry Supervisor further stated the facility curtains should be free of stains to ensure the facility was presentable and maintain infection control. On 8/19/24 at 1350 hours, an interview with the Administrator and DON was conducted. The Administrator and DON acknowledged above findings.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on interview, medical record review, facility P&P review, and facility document review, the facility failed to ensure the discharge process was properly followed for one of three sampled residents (Resident 150) reviewed for transfer and discharge. * Resident 150's medical record failed to show the physician's documentation Resident 150 was ready for discharge. This failure had the potential for an unsafe discharge from the facility for the resident. Findings: Review of the facility's P&P titled Transfer or Discharge Documentation (undated) showed the resident discharges or transfers because health of individuals in the facility would be endangered, the basis for the transfer or discharge must be documented in the resident's medical record by the attending physician. Medical record review for Resident 150 was initiated on 8/12/24. Resident 150 was admitted to the facility on [DATE]. Review of Resident 150's Notice of Proposed Transfer/discharge date d 6/4/24, showed Resident 150's discharge was appropriate because the safety of individuals in the facility was endangered due to Resident 150's noncompliant with the facility's policy related to bringing alcohol into the facility. Review of Resident 150's medical record failed to show any documented evidence Resident 150 was ready to discharge from the facility to the community. There was no documented evidence showing Resident 150's physician documented the basis for the resident's discharge prior to providing the notice to Resident 150. On 8/19/24 at 1552 hours, an interview was conducted with the Administrator. The Administrator stated Resident 150 did not have any noncompliant issue before the incident of alcohol found in the facility which was brought in by Resident 150. The Administrator verified the physician's documentation to show Resident 150's did not contain a basis for discharge.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683 Based on interview and medical record review, the facility failed to accurately coded the MDS assessments for four of 35 final sampled residents reviewed for the MDS assessments (Residents 52, 66, 127, and 161). * Resident 52's three MDS assessments were coded incorrectly for the resident's weight. * Resident 66's MDS was coded incorrectly regarding the resident's two falls. * Resident 127's MDS was coded incorrectly for the PASRR Level II screening. * Resident 161's MDS was not coded for the use of the CPAP machine. These failures had the potential for not providing necessary care and services to meet the care needs for these residents. Findings: 1. Review of CMS's Long Term Care Resident Assessment Instrument 3.0 User's Manual revised October 2023 showed for entering the resident's weights, use the most recent weight in the past 30 days, and if a resident cannot be weighed, use the standard no-information code (-). Medical record review for Resident 52 was initiated on 8/12/24. Resident 52 was readmitted to the facility on [DATE]. Review or Resident 52's Weight Summary showed the last recorded weight was 220 lbs on 9/4/23. Review of Resident 52's MDS assessments showed the following: - An MDS dated [DATE], showed the resident's weight as 220 lbs. - An MDS dated [DATE], showed the resident's weight as 220 lbs. - An MDS dated [DATE], showed the resident's weight as 220 lbs. On 8/14/24 at 1328 hours, an interview was conducted with Resident 52. Resident 52 stated the resident was last weighed almost a year ago and had been refusing to have the weight measured since it was too hard on the resident now to get weighed. On 8/14/24 at 1346 hours, an interview and concurrent medical record review were conducted with the MDS Coordinator. The MDS Coordinator reviewed Resident 52's medical record and stated it had been over 11 months since the resident was last weighed. The MDS Coordinator then reviewed the RAI tool and verified the RAI showed the resident's weights should have been coded with a (-) for no information for the above three MDS assessments. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Medical record review for Resident 66 was initiated on 8/12/24. Resident 66 was readmitted to the facility on [DATE]. Review of Resident 66's eINTERACT Change In Condition Evaluation - V 5.1 dated 5/25/24, showed the resident had a fall. Review of Resident 66's eINTERACT Change In Condition Evaluation - V 5.1 dated 5/28/24, showed the resident had a fall. Review of Resident 66's MDS dated [DATE], showed the resident did not have any falls since the last MDS assessment. Resident 66's previous MDS assessment was dated 4/15/24. On 8/15/24 at 0944 hours, an interview and concurrent medical record review was conducted with the MDS Coordinator. The MDS Coordinator reviewed Resident 66's eINTERACT Change In Condition Evaluations - V 5.1 dated 5/25 and 5/28/24, and verified the resident had two falls. The MDS Coordinator reviewed Resident 66's MDS dated [DATE], and verified the MDS was coded incorrectly and showed the resident did not have any falls since their previous assessment on 4/15/24. 3. Medical record review for Resident 127 was initiated on 8/12/24. Resident 127 was readmitted to the facility on [DATE]. Review of Resident 127's PASRR Individualized Determination Report dated 1/30/23, showed a Level II screening was completed and the resident had a significant medical condition with mental stressors that required nursing care and listed recommended specialized services to address the resident's mental health needs. Review of Resident 127's MDS dated [DATE], showed when asked if the resident was considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition, the assessment code was no. On 8/14/24 at 1512 hours, an interview and concurrent medical record review was conducted with the MDS Coordinator. The MDS Coordinator reviewed Resident 127's MDS dated [DATE], and PASRR Individualized Determination Report dated 1/30/23, and stated the resident did have a positive Level II screening and the MDS was coded incorrectly. 39670 4. Medical record review for Resident 161 was initiated on 8/12/24. Resident 161 was admitted to the facility on [DATE], with a diagnosis of sleep apnea (a serious sleep disorder in which breathing repeatedly stops and starts). Review of Resident 161's MDS dated [DATE], showed in Section O- Special Treatments, Procedures, and Programs, under the Non-invasive Mechanical Ventilator, the CPAP was left blank. Further review of the medical record showed the resident had an order for CPAP use. On 8/15/24 at 0906 hours, an interview and concurrent medical record review for Resident 161 was conducted with MDS Coordinator. The MDS Coordinator verified the above findings. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/19/24 at 1508 hours, an interview and concurrent medical record review for Resident 161 was conducted with the DON. The DON was informed and verified the above findings. Cross reference to F695, example #5.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47474 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the care plans for four of 35 final sampled residents (Residents 23, 73, 87, and 161) were developed and implemented. * The facility failed to develop a care plan for Humulin R insulin (medication used to lower blood sugar levels in the body) per sliding scale for Resident 87. * The facility failed to develop a care plan problem to address Resident 23's use of blood glucose (a simple sugar which is an important energy source in living organism) monitoring device. * The facility failed to develop a care plan problem to address Resident 161's use of CPAP machine at the bedside. * The facility failed to develope a care plan problem to address Resident 73's use of the following medications: Cymbalta, Insulin Lispro, Plavix, Seroquel, and Trazodone. These failures put the residents at risk of not receiving resident-centered care. Findings: Review of the facility's P&P titled Care Plans - Baseline revised 3/2022 showed a baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within 48 hours of admission. The P&P further showed the baseline care plan includes instructions needed to provided effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum health care information necessary to properly care for the resident including, but not limited to the following: a. Initial goals based on admission orders and discussion with the resident/representative; b. Physician orders; c. Dietary orders; d. Therapy services; e. Social services; and f. PASRR recommendations, if applicable (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's P&P titled Care Plans, Comprehensive Person-Centered revised 3/2022 showed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan is developed within seven days of the completion of the required MDS assessment (admission, annual, or significant change in status), and no more than 21 days after admission. 1. Medical record review for Resident 87 was initiated on 8/12/24. Resident 87 was admitted to the facility on [DATE], and readmitted back to the facility on [DATE]. Review of Resident 87's significant change MDS dated [DATE], showed Resident 87 had a BIMS score of 6 which meant the resident's cognition was severely impaired. Review of Resident 87 physician's orders dated August 2024 showed the following order: - dated 5/16/24, for Humulin R Injection Solution 100 unit/ml per sliding scale Review of Resident 87's Plan of Care showed no documented evidence a resident-centered care plan was initiated for Humulin R insulin. On 8/19/24 at 1321 hours, an interview and concurrent medical record review was conducted with LVN 8. LVN 8 verified Resident 87 had orders for Humulin R insulin per sliding scale; however, there was no resident-centered care plan for Humulin R insulin. On 8/19/24 at 1350 hours, an interview was conducted with the Administrator and DON. The Administrator and DON acknowledged above findings. 39670 2. Medical record review for Resident 23 was initiated on 8/14/24. Resident 23 was admitted to the facility on [DATE]. Review of Resident 23's Internal Medicine Progress Note dated 5/24/24, showed Resident 23 was admitted to the facility with the diagnosis including diabetes mellitus (a group of diseases that resulted in too much sugar in the blood). Review of Resident 23's plan of care failed to show documented evidence a care plan problem was developed to address Resident 23's use of the blood glucose monitoring device. On 8/15/24 at 1352 hours, an interview and concurrent medical record review for Resident 23 was conducted with RN 3. RN 3 verified there was no care plan formulated for Resident 23's use of the blood glucose monitoring device. Cross reference to F684, example #2. 3. Medical record review for Resident 161 was initiated on 8/12/24. Resident 161 was admitted to the facility on [DATE]. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 161's Admission Record dated 7/9/24, showed Resident 161 had a diagnosis of sleep apnea (a serious sleep disorder in which breathing repeatedly stops and starts). Review of Resident 161's plan of care failed to show documented evidence a care plan problem was developed to address Resident 161's use of CPAP machine at bedside. On 8/15/23 at 0906 hours, an interview and concurrent medical record review for Resident 161 was conducted with the MDS Coordinator. The MDS Coordinator verified there was no care plan was formulated for Resident 161's use of CPAP machine at bedside. On 8/19/24 at 1508 hours, an interview and concurrent medical record review for Residents 23 and 161 was conducted with the DON. The DON was informed of the findings and verified the above findings. Cross reference to F695, example #5. 43119 4. Review of the facility's P&P titled Care Plans, Comprehensive Person-Centered revised 3/2022 showed the interdisciplinary team (IDT), in conjunction with the resident and his/ her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. Medical record review for Resident 73 was initiated on 8/13/24. Resident 73 was admitted on [DATE], and readmitted to the facility on [DATE]. Review of Resident 73's quarterly MDS dated [DATE], showed Resident 73 had moderate cognitive impairment. Review of Resident 73's Order Summary Report dated August 2024 showed the following physician's orders: - dated 7/21/24, for Insulin Lispro (a fast-acting, synthetic insulin used to treat Type 1 and 2 diabetes) Injection Solution 100 unit/ml per sliding scale. - dated 7/22/24, for Cymbalta (a medication used to treat depression and anxiety) oral capsule 30 mg three capsules by mouth once daily. - dated 7/22/24, for Plavix (is an antiplatelet drug used to prevent blood clots) oral tablet 75 mg one tablet by mouth once daily. - dated 7/21/24, for Seroquel (is an antipsychotic medication used to treat several kinds of mental health conditions including schizophrenia and bipolar disorder) oral tablet 25 mg one-half tablet by mouth at bedtime -7/22/24, for Trazodone HCL (is a medication used to treat depression, anxiety, or a combination of depression and anxiety) oral tablet 50 mg give one tablet by mouth at bedtime (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 73's Plan of Care did not show the care plan was developed to address Resident 73's use of Cymbalta, Insulin Lispro, Plavix, Seroquel, and Trazodone. There were no documented care interventions in place to address Resident 73's above medications used . On 8/19/24 at 1450 hours, an interview and concurrent medical record review was conducted with LVN 16. LVN 16 verified Resident 73 had orders for Cymbalta, Insulin Lispro per sliding scale, Plavix, Seroquel, and Trazodone; however, did not have a resident-centered care plan for Cymbalta, Insulin Lispro per sliding scale, Plavix, Seroquel, and Trazodone. On 8/19/24 at 1510 hours, an interview and concurrent medical record review was conducted with RN 4. RN 4 verified the above findings. On 8/19/24 at 1604 hours, the DON was informed and acknowledged the above findings.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on observation, interview, medical record review and facility P&P review, the facility failed to ensure the comprehensive plan of care for one of 35 final sampled residents reviewed for care plans (Resident 46) was revised to reflect the residents' current care needs and interventions. * Resident 46's care plan for risk for aspiration and tube feeding intolerance was not revised to address the correct enteral feeding formula, free water, and infusing rate ordered. This failure posed the risk of not providing the resident with individualized and person-centered care. Findings: Review of the facility's P&P titled Care Plan's Comprehensive Person-Centered revised 3/22 showed a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. Assessments of the residents are ongoing and care plans are revised as information about the residents and the resident's condition change. On 8/13/24 at 1104 hours, Resident 46 was observed in bed with the head of bed elevated and the GT feeding of Glucerna (enteral feeding formula) 1.5 cal infusing at 55 ml/hr via GT. Resident 46 was also observed with free water infusing at 45 ml/hr via GT. Medical record review for Resident 46 was initiated on 8/12/24. Resident 46 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 46's H&P examination dated 2/14/23, showed Resident 46 did not have the capacity to understand and make decisions. Review of Resident 46's Order Summary Report for August 2024 showed the following physician's orders: - dated 6/24/24, to administer enteral feed every shift with the enteral feeding formula Glucerna 1.5 at a rate of 55 ml/hr for 20 hours, for a total of 1100 ml/1650 kcal; and to start at 1400 hours and off at 1000 hours or until dose met. - dated 6/24/24, to administer free water via enteral pump at 45 ml/hr for 20 hours, to provide 900 ml in 24 hours; and start at 1400 hours and off at 1000 hours or when volume was complete. Review of Resident 46's plan of care showed a care plan problem dated 6/14/23, addressing Resident 46's risk for aspiration and risk for enteral tube feeding intolerance. The care plan showed the intervention to administer the enteral feeding formula Diabetic Source via GT for a total of 1200 ml/1440 kcal at the rate of 60 ml/hr for 20 hours or until the dose was met. The care plan intervention also showed to administer free water via the enteral pump at 40 ml/hr for 20 hours to provide 800 ml in 24 hours. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/24 at 1042 hours, an interview was conducted with LVN 4. LVN 4 verified the above findings and stated the care plan should have been revised to reflect Resident 46's most current plan of care. On 8/19/24 at 1515 hours, an interview was conducted with the DON. The DON stated the care plans should be revised when there was a change in the resident's care, to provide resident-centered care. The DON was informed and acknowledged the above findings.

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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** 48882 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the quality care and services were provided for four of 35 final sampled residents (Residents 13, 23, 120, and 122). * The facility failed to ensure Resident 13's pacemaker (a small device placed in the chest to control abnormal heartbeat) was monitored for complications related to his pacemaker and failed to ensure the information regarding Resident 13's pacemaker was in his medical record as per the facility's P&P. * The facility failed to ensure a physician's order was obtained, the assessment was completed, and the appropriate instructions were obtained to maintain the appropriate care of a blood glucose monitoring device for two final sampled residents (Residents 23 and 120). * The facility failed to follow the physician's order for Resident 122 to receive a health shake (nutritional supplement) with meals. These failures had the potential for the residents to not receive the necessary care and services to maintain their highest physical well-being. Findings: 1. Review of the facility's P&P titled Pacemaker, Care of a Resident with revised 12/2015 showed if the pulse generator or battery fails, or if the leads become displaced, the pacemaker may not work properly, leading to bradyarrhythmias (abnormal heart rhythm that causes a resting heart rate to be abnormally slow). To monitor the resident for pacemaker failure by monitoring for signs and symptoms of bradyarrhythmia. Symptoms associated with bradyarrhythmias may include: syncope (fainting), shortness of breath, dizziness, fatigue, and/or confusion. To make sure the resident had a medical identification card that indicates he or she has a pacemaker. The medical record must contain this information as well. Further review of the facility's P&P showed for each resident with a pacemaker, to document the following in the medical record and on a pacemaker identification card upon admission: a. The name, address, and telephone umber of the cardiologist; b. Type of pacemaker; c. Type of leads; d. Manufacturer and model; e. Serial number; f. Date of implant; and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	g. Paced rate. Medical record review for Resident 13 was initiated on 8/12/24. Resident 13 was admitted to the facility on [DATE], with a diagnosis of presence of cardiac pacemaker. Review of Resident 13's H&P examination, dated 4/16/24, showed Resident 13 had congestive heart failure (heart is unable to pump enough blood to maintain the needs of the body) status-post pacemaker. Review of Resident 13's Order Summary Report for August 2024 failed to show any orders to monitor Resident 13 for pacemaker complications, such as low heart rate, low blood pressure, dizziness, or syncope. Review of Resident 13's Admission/Readmission Data Tool dated 4/9/24, failed to show documentation of the presence of Resident 13's pacemaker. Review of Resident 13's Admission Summary dated 4/9/24, failed to show documentation of Resident 13's pacemaker. Review of Resident 13's plan of care failed to show a care plan to address Resident 13's pacemaker. Further review of Resident 13's medical record failed to show documentation of Resident 13's cardiologist (a physician who treats heart conditions), type of pacemaker, pacemaker manufacturer, model, serial number, date of implant, and paced rate set on the pacemaker. On 8/19/24 at 1315 hours, an interview was conducted with RN 1. RN 1 was asked about the facility's policy for a resident with a pacemaker. RN 1 stated on admission, the residents were assessed for the presence of a pacemaker and documented in the admission assessment. RN 1 stated if the resident had a pacemaker, there would be a physician's order to monitor the resident for signs of pacemaker malfunction such as hypotension, low heart rate, syncope, or dizziness. When asked, RN 1 stated she was not aware Resident 13 had a pacemaker. On 8/19/24 at 1329 hours, an interview and concurrent observation of Resident 13 was conducted with RN 1. Resident 13 was observed with a pacemaker on the left side of chest. RN 1 verified the finding. On 8/19/24 at 1336 hours, an interview and concurrent record review for Resident 13 was conducted with RN 1. RN 1 verified the above findings. On 8/19/24 at 1515 hours, an interview was conducted with the DON. The DON stated for the residents admitted to the facility with a pacemaker, there should be monitoring of the resident's heart rate per the physician's order, and the residents medical record should contain a pacemaker information card with the following information: pacemaker setting, types of leads, serial number, type of pacemaker, and cardiologist contact information. The DON was informed and acknowledged the above findings. 39670 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Medical record review for Resident 23 was initiated on 8/14/24. Resident 23 was admitted to the facility on [DATE], with a diagnosis of diabetes mellitus (a group of diseases that resulted in too much sugar in the blood). On 8/14/24 at 1057 hours, an observation and concurrent interview was conducted with Resident 23. Resident 23 stated he monitored his blood sugar level with the use of blood sugar monitor placed on his left arm. Resident 23 stated the nurse placed the machine on the monitor probe and the blood sugar reading appeared automatically. Resident 23 was able to show the blood sugar monitor probe placed on his left arm. Review of Resident 23's Order Summary Report dated 8/14/24, showed a physician's order dated 10/18/22, to administer Humalog Kwikpen (fast acting insulin) solution per sliding scale subcutaneously before meals and at bedtime for DM as follows: if the blood sugar result = 151 to 200 mg/dl, no insulin; if blood sugar less than 70 mg/dl give orange juice and notify the Medical Doctor (physician); if the blood sugar result = 201 to 250 mg/dl, give 2 units of insulin; if the blood sugar result = 251 to 300 mg/dl, give 4 units of insulin; if the blood sugar results = 301 to 350 mg/dl, give 6 units of insulin; if the blood sugar results = 351 to 400 mg/dl, give 8 units of insulin; and if the blood sugar more than 400 mg/dl, give 10 units of insulin and notify the Medical Doctor. However, there was no physician's order for the use of the blood glucose monitoring device and care for the monitor probe placed on the resident skin documented. Further review of Resident 23's medical record failed to show documented evidence for the use of the blood glucose monitoring device. On 8/14/24 at 1436 hours, an interview for Resident 23 was conducted with LVN 15. LVN 15 verified Resident 23 was on blood glucose monitoring and using the Freestyle (a continuous blood sugar monitoring system which provides real time blood sugar readings and can be accessed via a mobile device) blood glucose monitor device. LVN 15 stated Resident 23 had the blood glucose monitoring probe placed on the left arm. LVN 15 was able to show the blood glucose monitoring device and stated he placed the monitoring device on top of the probe, and it would show the result of the blood glucose level of the resident. LVN 15 verified there was no physician's order for the use of the monitoring blood glucose device and care for the probe embedded in the skin of the resident. LVN 15 also verified there were no assessment and documentation about the blood glucose monitoring device. On 8/15/23 at 1352 hours, an interview and concurrent medical record review for Resident 23 was conducted with RN 3. RN 3 verified there was no physician's order for the use of the blood glucose monitoring device and care of the skin where the probe was placed. Cross reference to F656, example #2. 3. On 8/12/24 at 1129 hours, during the initial rounds of the facility, an observation and concurrent interview was conducted with Resident 120. Resident 120 stated she had diabetes and continuously monitoring her blood sugar. Resident 120 stated she had a blood glucose scanner called Dexcom 7 (a continuous blood sugar monitoring system which provides real time blood sugar readings and can be accessed via a mobile device). Resident 120 was able to show the blood glucose monitoring probe placed on her abdomen. Resident 120 stated she placed the probe and cover with transparent dressing. Resident 120 stated she changed the blood glucose monitor probed every ten days. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident 120 was initiated on 8/14/24. Resident 120 was admitted to the facility on [DATE], with a diagnosis of diabetes mellitus (a group of diseases that resulted in too much sugar in the blood). Review of Resident 120's Order Summary Report dated 8/15/24, failed to show a physician's order for the use of the blood glucose monitoring device since admission of the resident and the care of the monitor probe placed on the skin of the resident. Review of Resident 120's care plan showed a care plan problem dated 7/30/24, addressing Resident 120's diagnosis of diabetes. There was no documented evidence a care plan problem was developed to address Resident 120's DEXCOM 7 device, with interventions to show monitoring of the probe device, surrounding tissue, dressing changes, etc,. On 8/14/24 at 0840 hours, an interview and concurrent medical record review for Resident 120 was conducted with LVN 14. LVN 14 stated he was aware of the resident using the DEXCOM blood glucose monitor. LVN 14 stated Resident 120 refused sometimes to do the finger stick blood sugar check because it was hurting her finger and so they used and based the blood glucose reading on Resident 120's blood glucose monitoring device machine. LVN 14 verified there were physician's order to monitor the blood sugar via finger stick before meals and acknowledged there was no physician's order to monitor the blood sugar result and have an insulin sliding scale based on the result on the DEXCOM blood sugar monitor device. LVN 14 verified there were no physician's order for the care and maintenance of the device, such as skin care on the placement of the monitor probe. On 8/14/24 at 0842 hours, an interview and concurrent medical record review for Resident 120 was conducted with RN 2. RN 2 verified there were no assessment and physician's order for the use of the DEXCOM 7 blood glucose monitoring device. On 8/19/24 at 1508 hours, an interview and concurrent medical record review for Residents 23 and 120 was conducted with the DON. The DON was informed and verified the above findings. 48853 4. Medical record review for Resident 122 was initiated on 8/12/24. Resident 122 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of the Order Summary Report dated 8/14/24, showed a physician's order dated 9/11/23, for a health shakes with meals. During the lunch meal observation on 8/12/24 at 1225 hours, in the dining room, Resident 122's lunch meal tray ticket showed a fortified high protein diet pureed texture with one health shake. However, the lunch meal for Resident 122 did not include a health shake. CNA 1 confirmed the health shake was missing and stated he would get one from the kitchen.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services related to pressure injuries (areas of damaged skin caused by staying in one position for a long time which reduces blood flow to the area and causes the skin to die and develop a sore) were provided for one of three final residents (Resident 13) reviewed for pressure injuries. * Resident 13's wound treatments was not performed as per the physician's orders. * The facility failed to ensure Resident 13's heels were offloaded (suspension of the heel in the air by placing pillows under the lower leg so as not to place pressure on the Achilles tendon and the heel to prevent or heal ulcers, wounds, and other conditions) as per the physician's order. These failures have the potential to delay Resident 13's wound healing. Findings: 1. Review of the facility's P&P titled Wound Care revised 2/24 showed the purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Under the section Steps in the Procedure, showed to clean the wound as ordered. Medical record review for Resident 13 was initiated on 8/12/24. Resident 13 was admitted to the facility on [DATE], and had a diagnosis of unstageable (not stageable due to coverage of the wound bed by slough and/or eschar) pressure ulcer of the right heel. Review of Resident 13's MDS dated [DATE], showed Resident 13 was at risk for pressure injuries and had an unhealed and unstageable pressure injury. a. Review of Resident 13's Order Summary Report showed a physician's order dated 6/10/24, for the right heel pressure injury, to cleanse with normal saline (NS), pat dry, apply Santyl (topical medicine that removes dead tissue from wounds to promote wound healing) and mupirocin (topical medicine used to treat secondarily infected traumatic skin lesions due to specific bacteria) to the wound bed and cover with foam dressing one time a day and as needed if dislodged or soiled. Review of Resident 13's Treatment Administration Record (TAR) for August 2024 showed the wound treatments were provided for Resident 13's right heel from 8/1 to 8/15/24. Review of Resident 13's plan of care showed a care plan problem dated 6/12/24, addressing Resident 13's altered skin integrity related to pressure ulcer on the right heel, unstageable. The care plan interventions included to administer treatment as ordered and monitor/report effectiveness vs side effects. The interventions also showed to cleanse the right heel with NS, pat dry, apply Santyl and mupirocin to the wound bed and cover with the foam and dressing one time a day and as needed if dislodged or soiled as ordered. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/15/24 at 0811 hours, a wound treatment observation was conducted with LVN 3 and the Wound Consultant. The Wound Consultant was observed cleansing Resident 13's right heel pressure injury with a Gentell wound cleanser. On 8/15/24 at 1244 hours, an interview and concurrent record review for Resident 13 was conducted with LVN 3. LVN 3 reviewed Resident 13's treatment orders for the right heel pressure injury and verified NS was not used to cleanse the right heel pressure injury during the wound treatment observation. LVN 3 stated when the Wound Consultant conducted her weekly wound evaluations, she preferred to use wound cleanser to cleanse the wounds. LVN 3 was asked if there was a physician's order for wound cleanser to be used to cleanse Resident 13's wounds when the Wound Consultant was at the facility to conduct wound evaluations. LVN 3 stated there were no orders for wound cleanser to be used. LVN 3 further stated wound treatments should be administered per the physician's order and the physician should be notified if a different product was being used. On 8/19/24 at 0856 hours, a telephone interview was conducted with the Wound Consultant. The Wound Consultant stated normal saline and wound cleanser were not the same products. The Wound Consultant stated if the order was to cleanse with normal saline, normal saline should be used to cleanse the wound. On 8/19/24 at 1515 hours, an interview was conducted with the DON. The DON stated the treatments should be administered as ordered by the physician and if a different product was used, there should be a new order by the physician. The DON was informed and acknowledged the above findings. 39453 b. Review of Resident 13's Order Summary Report dated 8/13/24, showed the following physician's orders dated: - 4/16/24, to apply heel boots on bilateral lower extremities for skin maintenance; and - 7/3/24, to offload heels with pillows while not wearing heel boots every shift for skin maintenance. Review of Resident 13's Plan of Care showed a care plan problem addressing Resident 13's altered skin integrity related to pressure ulcer on the right heel. One of the interventions included to float the heels with pillow while in bed if indicated. On 8/13/24 at 0815 hours, an observation for Resident 13 and concurrent interview was conducted with CNA 12. CNA 12 was asked to go to Resident 13's room. When asked about Resident 13's skin condition, CNA 12 stated Resident 13 had a pressure ulcer on the heels. When asked to lift Resident 13's blanket, Resident 13 was observed not wearing the boots, and both heels were touching the surface of the pillow. CNA 12 verified the findings. On 8/14/24 at 0912 hours, an interview was conducted with CNA 13. CNA 13 was asked if she put anything to Resident 13's heels or offloaded Resident 13's heels, CNA 13 answered no and stated Resident 13 did not have any skin condition, but only dry skin on the legs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/24 at 1037 hours, LVN 3 and CNA 13 were observed providing care to Resident 13. LVN 3 and CNA 13 were observed repositioning Resident 13. LVN 3 and CNA 13 did not apply boots to Resident 13 but observed placing a pillow underneath Resident 13's lower leg. Resident 13's left heel was observed touching the surface of the mattress and his right heel was touching the left heel. Then, LVN 3 and CNA 13 were observed placing a blanket over Resident 13. On 8/14/24 at 1046 hours, an observation for Resident 13 and concurrent interview and medical record review for Resident 13 was conducted with LVN 3. LVN 3 stated Resident 13 had a pressure ulcer on the right heel and was supposed to wear the boots, or offload the heels. LVN 3 was asked to lift Resident 13's blanket, Resident 13 was observed not wearing the boots, and his left heel was observed touching the surface of the mattress and his right heel was touching the left heel. LVN 3 verified the above findings.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary care and services to ensure the facility's four of four dryers and two of 35 final sampled residents (Residents 13 and 87) were free from accident hazards. * The facility failed to ensure the lint screen on all four dryers were brushed and cleaned after every load or every hour per the facility's P&P. In addition, the facility failed to ensure there were no exposed foam in one dryer causing the lint to stick to the foam, and the lint was not removed thoroughly. These failures had the risk for causing fire in the facility. * The facility failed to provide one to one feeding and supervision with meals for Resident 13 and failed to ensure Resident 13 was not given whole pills. In addition, the facility failed to ensure Resident 13 was transferred from wheelchair to bed with a two-person assist. These failures had the potential for aspiration/choking and fall/injury for this resident. * The facility failed to ensure Resident 87 was monitored upon readmission after fall with injury. This failure had the potential for a delay in providing care to the resident. Findings: 1. Review of the facility's P&P titled Laundry Operations revised date 9/5/17, under Lint Screens, showed the following: - Lint screens must be brushed and cleaned after every load or every hour. If not, the screen will become packed with lint. When this occurs, the warm air moving through the system is blocked, raising the temperature in the basket, and causing a potentially dangerous situation, such as where one spark on lint can cause a fire. Torn of improperly fitted screens must be reported to facility maintenance personnel via a work order for immediate repair; - Lint build up between the drum and the sides of the dryer is the root cause of many dryer fires. This may cause a problem because in many dryers there is a heat sensor there. This sensor reads the heat of the basket and is programmed to shut the dryer down if the temperature gets too hot. So if the sensor is covered with lint, the lint acts as insulation and fools the sensor into thinking the basket is not as hot as it really is, instead of shutting the dryer down, it allows the heat to continue to pour in. It is extremely important to remove the entire front of the dryer and vacuum the entire interior; and - Lint build-up on the top compartment of the dryer is dangerous because the heat source is here. The top panel must be opened and the area must be cleaned daily. Review of the facility's document titled Dryer Lint Clean Out Schedule for August 2024 showed the dryer lint was cleaned out at 8/14/24, at 1000 hours. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/14/24 at 0951 hours, an inspection of the laundry area and concurrent interview and facility document review was conducted with the Housekeeping and Laundry Supervisor. When asked about the lint screens on the dryers, the Housekeeping and Laundry Supervisor stated they cleaned the lint screen every hour. The Housekeeping and Laundry Supervisor stated one of the laundry personnel cleaned the lint screen on all four dryers five minutes ago and documented in the Dryer Lint Clean Out Schedule form. When asked to open the lint compartment to check the lint screens of the four dryers, all four dryers were observed full of lint. In addition, one of the dryers was observed with an exposed foam in the inner panels of the lint compartment, which caused the lint to stick to the foam. The Housekeeping and Laundry Supervisor verified the above findings. 2. Medical record review for Resident 13 was initiated on 8/12/24. Resident 13 was admitted to the facility on [DATE]. a. Review of Resident 13's Order Summary Report dated 8/13/24, showed the following physician's order: - dated 4/9/24, for aspiration precautions: one to one feeding, sit upright 90 degrees for all meals and medication administration, and no straw; - dated 5/6/24, to provide regular NAS (no added salt) diet, pureed/ level 4 texture, and honey moderately thick consistency; and - dated 7/5/24, for supervision with meals. Review of Resident 13's Plan of Care showed a care plan problem dated 7/2/24, addressing nutrition. The interventions included one to one assistance with feeding and assist resident during mealtime. On 8/13/24 at 0806, 0815, and 0824 hours, Resident 13 was observed awake, and sitting up in bed. A breakfast tray was observed in front of the resident and Resident 13 was observed eating by himself. On 8/13/24 at 0815 hours, an observation for Resident 13 and concurrent interview with CNA 12 was conducted. Resident 13 was observed awake and sitting up in bed. A breakfast tray was observed in front of the resident and Resident 13 was observed eating by himself. CNA 12 verified Resident 13 was eating and feeding himself. CNA 12 stated Resident 13 could feed himself and she would just come to check on him. On 8/13/24 at 1231 hours, Resident 13 was observed awake and sitting up in bed. A lunch tray was observed in front of the resident and Resident 13 was observed eating by himself. On 8/13/24 at 1257 hours, an observation for Resident 13 and concurrent interview and medical record review with RN 1 was conducted. Resident 13 was observed awake and sitting up in bed. A lunch tray was observed in front of the resident. Resident 13 was observed asking for help, and a cup containing water observed to have spilled. RN 1 verified he was served with a meal tray, and Resident 13 fed himself. RN 1 stated Resident 13 was on supervised feeding, and he used to be on one to one feeding. When asked about supervised feeding, RN 1 stated the CNAs would come and check on him, to come and peek to see how he is eating. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/19/24 at 1046 hours, an interview was conducted with the DSD. When asked about one to one feeding and supervised feeding, the DSD stated one to one feeding and supervised feeding were almost the same thing, where one to one feeding meant the staff would feed the resident, while supervised feeding meant the resident could feed themselves but a staff had to be in the room with the resident. The DSD stated the staff had to be in the room to monitor the resident in one to one feeding and supervised feeding, during the entire duration of the feeding. b. On 8/13/24 at 0858 hours, a telephone interview was conducted with Family Member 3. Family Member 3 stated a charge nurse gave Resident 13 whole pills on 7/27 or 7/28/24. Review of Resident 13's Order Summary Report dated 8/13/24, showed the following physician's order: - dated 4/18/24, may crush all crushable medications and add/mix with applesauce due to aspiration precautions. On 8/15/24 at 0842 hours, an interview and concurrent medical record review for Resident 13 was conducted with the DON. When asked if he was informed about an incident when Resident 13 was forced by a charge nurse to take the whole pills, the DON stated she was informed by Family Member 3 about the incident. The DON stated he investigated and identified LVN 11 as the charge nurse. The DON stated LVN 11 admitted giving whole medications instead of crushing them. The DON stated he could not remember the date and time when LVN 11 gave the whole medications. Review of Resident 13's MAR for July and August 2024 did not show any documentation LVN 11 administered medications to Resident 13. On 8/15/24 at 1357 hours, an interview and concurrent facility document review was conducted with the Administrator. The Administrator stated the ADON filed a grievance report of the incident reported by Family Member 3 about a charge nurse giving a whole medication to Resident 13. Review of the facility's document titled Grievance/Complaint Resolution Report dated 8/2/24, showed Family Member 1 was concerned about a small nurse who did not crush medication. The grievance report, under Administrative Processing, showed the DON identified and inserviced the nurse. Review of the facility's document titled 1:1 Inservice Record dated 8/3/24, showed an education on following the physician's orders, administering, and how to prepare/crush medications to LVN 11. c. Review of the OT Treatment Encounter Notes dated 6/10/24, showed Resident 13 needed maximum assist with two-person assist for sit to stand/transfers. Review of Resident 13's MDS dated [DATE], showed Resident 13 was dependent from the staff for sit to stand transfer. Review of the eINTERACT Change of Condition Evaluation dated 7/26/24, showed the resident was being transferred from wheelchair to bed when the resident accidentally bumped his left lateral leg on the wheelchair, causing the resident to sustain a skin tear on the left leg. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/14/23 at 1356 hours, an interview for Resident 13 was conducted with RNA 2. When asked about the incident on 7/26/24, RNA 2 stated while he was transferring Resident 13 from wheelchair to bed, Resident 13 stretched his left leg and might have hit the wheelchair, which caused the skin tear. When asked how many staff transferred Resident 13 from wheelchair to bed, RNA 2 stated he transferred the resident by himself, and without any other staff assistance. On 8/15/24 at 1241 hours, an interview and concurrent medical record for Resident 13 was conducted with the OT. When asked about Resident 13's OT assessment, the OT stated per the OT encounter note, Resident 13 needed maximum assistance with two-person for sit to stand/transfers. The OT stated if Resident 13 needed maximum assist with transfers, the resident needed a Hoyer lift to be transferred for safety. 47474 3. Review of the facility's P&P titled Admission Assessment and Follow Up: Role of the Nurse revised 9/2012, showed the purpose of this procedure is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purpose of managing the resident, initiating the care plan, and completing required assessment instruments, including the MDS. The P&P further showed documentation should be recorded in the resident's medical record and include the following: a. The date and time the assessment was performed. b. The name and title of the individual(s) who performed the procedure. c. All relevant assessment data obtained during the procedure. d. How the resident tolerated the assessment. e. Orders obtained from the physician. f. The signature and title of the person recording the data. Medical record review for Resident 87 was initiated on 8/12/24. Resident 87 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 87's significant change MDS dated [DATE], showed Resident 87 had a BIMS score of 6 which meant the resident's cognition was severely impaired. Review of Resident 87's care plan titled Pain dated 5/16/24, showed alteration in comfort due to pain related to the disease process, osteoporosis (disease that weakens the bones), status post fall with left orbital fracture (broken bones surrounding the eye), subdural hematoma (a medical condition of bleeding in the brain), and on routine pain medication of Tylenol 500 mg every 12 hours for pain management. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 87's facility document titled Admission Summary dated 5/16/24, showed Resident 87 was readmitted back to the facility from the acute care hospital with an admitting diagnosis including subdural hematoma (a pool of blood between the brain and its outermost covering), orbital fracture (breaks in any of the bones surrounding the eye area), and left vision loss. Further review of Resident 87's progress notes showed no documented evidence of every shift, 72-hours monitoring upon return from the acute care hospital. On 8/19/24 at 1009 hours, an interview was conducted with LVN 13. LVN 13 stated the new admissions and residents returning from hospital were monitored and charted on every shift for 72-hours. LVN 13 stated monitoring residents every shift for 72-hours ensured the residents' conditions properly supervised as a new admission or readmission back from hospitalization . On 8/19/24 at 1321 hours, an interview and concurrent medical records review with LVN 8 was conducted for Resident 87. LVN 8 verified Resident 87 had a fall at the facility on 5/10/24, and returned to the facility from the acute care hospital on 5/16/24. LVN 8 stated the residents readmitted from hospitalization were on every shift, 72-hours monitoring which was charted on the resident's progress notes. LVN 8 further stated monitoring the residents ensured the facility was able to care for the residents and assess for changes in the residents' conditions compared from their baseline. LVN 8 verified Resident 87 did not have every shift, 72-hours documentation upon return from the acute care hospital; however, LVN 8 stated the facility should have after readmission from a fall with injury. On 8/19/24 at 1350 hours, an interview with the Administrator and DON was conducted. The DON stated the residents who returned from the acute care hospital after 72 hours were considered a new admit. The DON further stated he expected the licensed nurses to document every shift for 72-hours for all new admissions and residents readmitted back from the acute care hospital. The DON stated the facility had a Daily Skilled Notes charting which were completed once a day and did not replace the every shift, 72-hours monitoring. Furthermore, the DON stated monitoring every shift for 72-hours ensured the facility assessed the resident's condition and plan of care. The Administrator and DON acknowledged above findings.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39856 Based on interview, medical record review, and P&P review, the facility failed to ensure the nutritional status was assessed per the facility's P&P for one of 35 final sampled residents (Resident 25.) This failure posed the risk of nutritional interventions not being implemented in a timely manner. Findings: Review of the facility's P&P titled Nutrition Assessment revised 10/2017, showed in part, 1. The dietitian, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission (within current baseline assessment timeframes) and as indicated by a change in condition that places the resident at risk for impaired nutrition .3. The nutritional assessment will be conducted by the multidisciplinary team and shall identify at least the following components: d. Dietitian: 1) An estimate of calorie, protein, nutrient and fluid needs; 2) Whether the resident's current intake is adequate to meet his or her nutritional needs . Review of the facility document titled MNA (Mini Nutritional Assessment- a screening and assessment tool that can identify geriatric patients age 65 and above who are malnourished or at risk of malnutrition) showed normal nutritional status score 24-30 points; at risk of malnutrition score 17-23.5 points; and malnourished less than 17 points. Medical record review for Resident 25 was initiated on 8/15/24. Resident 25 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 25's weight and vital signs summary showed the following: - on 5/14/24, the admission weight of 118 lbs., - on 6/10/24, a weight of 116 lbs., - on 6/18/24, the readmission weight of 110 lbs, 8 lbs or 6.7% significant weight loss since 5/14/24. Review of the IDT Weight Management Assessment completed on 6/18/24, by RD 1 showed in part, Resident 25 had experienced weight loss of six pounds in one week/month and weight loss was likely unavoidable related to elevated WBC, to FU (follow up) PRN (as needed). Resident 25's calorie, protein, and fluid needs and assessment of Resident 25's intake were not included in the IDT weight management assessment. Review of the IDT Wound Management Assessment completed on 6/19/24, by LVN 5 showed in part, sacrococcygeal (tailbone) unstageable PI present upon readmission on 6/17/24. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 25's progress notes completed by RD 1 on 6/23/24, showed to improve skin integrity due to pressure sore. Add Prostat (a protein supplement) 30 ml QD (every day), vitamin C, Zinc (supplement) x 14 days. Needs estimate: 1300-1800 calories, 60-100 gm of protein, 1300-1800 cc of water. Resident 25's intake was not assessed to determine if her intake was meeting the estimated calorie, protein, and fluid needs. Review of the Mini Nutrition Assessment completed by the DSS on 7/2/24, showed in part, Resident 25 had a moderate decrease in food intake, weight loss between 1 and 3 kg (kilogram), nutritional status score: 6 (0-7 points: malnourished). Review of the Nutrition Assessment completed by RD 1 on 7/2/24, showed in part, intake 51-75% of meals, skin ulcers: stage 3, 4, DTI, unstageable, difficulty swallowing, estimated caloric needs: 1200-1800 calories, estimated fluid needs: 1200-1800, estimated protein needs: 60-100 gm, Comment/Recommendations: resident with history of significant weight changes mostly recently trending weight loss .PO (oral) intake remains moderate to good . pressure sore noted. The Nutrition Assessment did not include an assessment of Resident 25's intake and whether it met her estimated calorie, protein, or fluid needs. On 8/15/24 at 1416 hours, a telephone interview was conducted with the [NAME] President of Integrated Services (VPIS). The VPIS confirmed the P&P titled Nutritional Assessment showed the RD was responsible to assess the resident's current intake with their nutritional needs. The VPIS stated the facility used the MNA scoring system to prioritize nutrition assessments. The VPIS stated her expectation of completion of the MNA nutritional screening was within the 72-hours of admission and high-risk residents should be assessed by the RD within seven days of screening. The VPIS added the facility technically had 14 days to complete the nutritional assessment. Resident 25's medical record was reviewed with the VPIS. The VPIS confirmed RD 1 failed to assess Resident 25's intake with her estimated calorie, protein, and fluid needs. The VPIS stated she had noticed during her visits to the facility, RD 1 calculated the residents' calorie, protein, and fluid needs; however did not assess whether the residents' intake was meeting their estimated calorie, protein, and fluid needs. The VPIS provided an email dated 6/21/24, addressed to the facility's Administrator, RD 1, and the DON with a summary of her visit which included recommendations to include the resident's estimated energy (calorie) and protein needs and include the % of needs met and to address % of meals and supplements consumed.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on interview, and medical record review, the facility failed to provide the necessary care and services to maintain the intravenous accesses for one of one sampled resident (Resident 161) reviewed for IV care. * The facility failed to ensure a physician's order was obtained for the peripheral intravenous access sites rotation every 72 hours and as needed. This failure had the potential to delay the identification of intravenous complication of the resident. Findings: Medical record review for Resident 161 was initiated on 8/12/24. Resident 161 was admitted to the facility on [DATE], with a diagnosis of local infection of the skin and subcutaneous tissue (deepest layer of the skin). Review of Resident 161's Internal Medicine History & Physical/Progress Note dated 7/10/24, showed Resident 161 had the mental capacity to make medical decisions. Review of Resident 161's Order Summary Report dated 8/15/24, showed a physician's order dated 8/14/24, to administer daptomycin (antibiotic) 600 mg intravenously one time a day for skin infection for 14 days. Review of Resident 161's Plan of Care showed a care plan problem dated 8/13/24, addressing Resident 161's intravenous therapy. The plan of care interventions included to rotate the peripheral sites every 72 hours and as needed. On 8/14/24 at 0811 hours, an interview and concurrent medical record review for Resident 161 was conducted with RN 3. RN 3 verified Resident 161 was on IV antibiotic for skin infection. RN 3 verified the peripheral IV access was on the left wrist of Resident 161. RN 3 was asked if there was a physician's order to rotate the IV access sites every 72 hours and as needed. RN 3 verified there was no physicians order to rotate the peripheral IV access sites. On 8/19/24 at 1508 hours, an interview and concurrent medical record review for Resident 161 was conducted with the DON. The DON was informed of the above finding and verified the finding.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure seven of eight final sampled residents (Residents 1, 46, 53, 81, 107, 142, and 161) with respiratory orders were properly maintained and administered as ordered. * The facility failed to ensure Resident 1's oxygen tube was dated and labeled. * The facility failed to ensure Resident 81's CPAP mask had a storage bag. * The facility failed to ensure Resident 107 received oxygen as ordered, oxygen nasal cannula was properly labeled and had an oxygen storage bag. * The facility failed to ensure Resident 142's oxygen tubing was labeled, dated, and placed in a plastic bag when not in use. * The facility failed to ensure Resident 161 had a physician's order for CPAP use with a CPAP machine at the bedside. * The facility failed to ensure Resident 46 received oxygen at 2 liters per minute via nasal cannula as per the physician's order. * The facility failed to follow the physician's order for Resident 53's oxygen therapy. These failures had the potential for the residents to not receive oxygen as ordered and adequate respiratory care. Findings: Review of the facility's P&P titled Oxygen Administration revised on 2/2024 showed oxygen therapy is administered by way of an oxygen mask, nasal cannula, and/or nasal catheter. a. The oxygen mask is a device that fits over the resident's nose and mouth. It is held in place by an elastic band laced around the resident's head. b. The nasal cannula is a tube that is placed approximately one-half inch into the resident's nose. It is held in place by an elastic band placed around the resident's head. c. The nasal catheter is a piece of tubing inserted through the resident's nostrils into the back of his/her mouth. It is held in place by a piece of skin tape attached to the resident's forehead and/or check. 1. Medical record review for Resident 1 was initiated on 8/12/24. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's annual MDS dated [DATE], showed Resident 1 had a BIMS score of 3 which meant the resident's cognition was severely impaired. Review of Resident 1's physician's orders dated August 2024 showed the following physician's orders: - dated 8/18/24, to change oxygen nasal cannula every week on Sunday and as needed (with name and date label) every night shift and oxygen humidifier every week on Sunday and as needed when consumed (with name and date label). On 8/12/24 at 0816 hours, an observation was conducted in Resident 1's room. Resident 1 was observed with an oxygen via nasal cannula not dated with the name and date attached to an oxygen concentrator. On 8/12/24 at 0842 hours, an observation and concurrent interview with the IP was conducted. The IP verified Resident 1's oxygen nasal cannula tube was not labeled with the date and name as ordered by the physician. The IP stated the oxygen nasal cannula tube should be labeled with the name and date as ordered, and to ensure the correct resident was receiving the oxygen and for infection control. The IP further stated the nasal cannula were to be changed weekly on Sunday night to prevent mold and bacteria build up. On 8/19/24 at 1350 hours, an interview with the Administrator and DON was conducted. The Administrator and DON acknowledged above findings. 2. Medical record review for Resident 81 was initiated on 8/12/24. Resident 81 was admitted to the facility 9/1/23. Review of Resident 81's quarterly MDS dated [DATE], showed Resident 81 had a BIMS score of 15 which meant the resident was cognitively intact. Review of Resident 81's physician's orders dated August 2024 showed the following physician's orders: - dated 9/8/23, for CPAP machine cleaning: Wipe machine with warm, soapy water and rinse at least once a week on Saturdays and as needed everyday shift on Saturdays. - dated 9/8/23, to monitor the CPAP machine functionality and placement every 3-11 and 11-7 shifts every evening and night shift. - dated 9/8/23, to apply CPAP with nasal mask at night and off when awake. On 8/12/24 at 0947 hours, an observation was conducted in Resident 81's room. A CPAP machine was observed on top of Resident 81's bedside drawer and the CPAP nasal mask observed on the resident's bed. The CPAP nasal mask was observed not stored inside a storage bag. Resident 81 stated he wears a CPAP at night and during the day when he takes a nap. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/12/24 at 1045 hours, an observation and concurrent interview with LVN 7 was conducted in Resident 81's room. LVN 7 verified Resident 81's CPAP nasal mask was on the resident's bed and not properly stored in a bag. LVN 7 stated the CPAP nasal mask was stored in a storage bag for infection control as the CPAP nasal mask could harbor bacteria if not stored properly. On 8/19/24 at 1350 hours, an interview with the Administrator and DON was conducted. The Administrator and DON acknowledged above findings. 3. Medical record review for Resident 107 was initiated on 8/12/24. Resident 107 was admitted to the facility on [DATE]. Review of Resident 107's quarterly MDS dated [DATE], showed Resident 107 had a BIMS score of 13 which meant the resident was cognitively intact. Review of Resident 107's physician's orders dated August 2024 showed the following physician's orders: - dated 5/31/24, to administer oxygen at 2 liters per minute via nasal cannula every shift, . - dated 10/1/23, to change the oxygen nasal cannula every week on Sunday and as needed (with name and date label) one time a day every Sunday and oxygen humidifier every week on Sunday and PRN when consumed (with name and date label) at bedtime every Sunday. On 8/12/24 at 0900 hours, an observation in Resident 107's was conducted. Resident 107 was observed wearing an oxygen nasal cannula not dated with the name and date as ordered by the physician and the oxygen concentrator was observed turned off. Further observation showed Resident 107 did not have an oxygen storage bag. Resident 107 stated he was on continuous oxygen. On 8/12/24 at 0908 hours, and observation and concurrent interview with LVN 2 was conducted in Resident 107's room. LVN 2 verified the oxygen concentrator was turned off and stated Resident 107 was on continuous oxygen. LVN 2 further verified the oxygen nasal cannula was not labeled with the name and date and there was oxygen storage bag. LVN 2 stated the oxygen should be administered as ordered and if the resident did not want the oxygen, she would have to inform the resident's physician for as needed oxygen orders. LVN 2 stated the oxygen nasal cannula should be properly labeled with a storage bag available for infection control. On 8/19/24 at 1350 hours, an interview with the Administrator and DON was conducted. The Administrator and DON acknowledged above findings. 39670 4. On 8/12/24 at 1029 hours, during the initial tour of the facility, a concurrent observation and interview was conducted with Resident 142. Resident 142 stated she used oxygen therapy occasionally. A portable oxygen was observed placed behind Resident 142's wheelchair with an oxygen tubing hung on the handle of the wheelchair unlabeled and undated. Medical record review for Resident 142 was initiated on 8/12/24. Resident 142 was admitted to the facility on [DATE]. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 142's Physician H&P and Progress note dated 7/17/24, showed under the Resident Capacity section, Resident 142 had the capacity to understand and make decisions. Review of Resident 142's Order Summary Report dated 8/13/24, showed a physician's order dated 7/30/24, to administer oxygen at two liters per minute via nasal cannula as needed for shortness of breath. On 8/13/24 at 1222 hours, an observation and concurrent interview for Resident 142 was conducted with RN 2. RN 2 verified the oxygen nasal cannula tubing was unlabeled and placed on the handle of the wheelchair. RN 2 stated the oxygen tubing should have been labeled and placed on a respiratory bag when not in use. On 8/19/24 at 1306 hours, an interview and concurrent medical record review for Resident 142 was conducted with the DON. The DON was informed of the above findings and verified the findings. 5. Review of the facility's P&P titled CPAP/BiPAP Support dated 3/2015 showed to review the physician's order and the resident medical record to determine the oxygen need of the resident in preparation for the use of CPAP machine. Under the general guidelines for cleaning of the CPAP machine showed a specific cleaning instructions should be obtained from the manufacturer of the device. Documentation in the resident's medical record should include the device started and duration of the therapy, mode and setting of the device, oxygen concentration and flow of the device, and the oxygen saturation during the therapy. On 8/12/24 at 1131 hours, during the initial tour of the facility, a concurrent observation and interview was conducted with Resident 161. Resident 161 was observed with a CPAP machine on top of the bedside drawer. Resident 161 stated the CPAP tubing and mask were inside the drawer. Review of the ResMed AirSence 10 (C-PAP machine) user guide (undated) showed under the caring for the device section to regularly clean the tubing assembly, water tub, and mask to prevent the growth of the germs that can adversely affect the health of the resident. Medical record review for Resident 161 was initiated on 8/12/24. Resident 161 was admitted to the facility on [DATE] with a diagnosis of sleep apnea (a serious sleep disorder in which breathing repeatedly stops and starts). Review of Resident 161's Internal Medicine H&P/Progress Note dated 7/10/24, showed Resident 161 had the mental capacity to make medical decisions. Review of Resident 161's Order Summary Report dated 8/15/24, showed a physician's order dated 8/14/24, to apply CPAP ResMed Airsense 10 with a setting: Pressure 5.0. humidifier 4.0 Auto 72 degrees at bedtime and remove in AM. However, the physician's order for CPAP machine use for Resident 161 was 37 days after admission. On 8/13/24 at 1456 hours, an interview was conducted with CNA 14 for Resident 161. CNA 14 verified Resident 161's use of the CPAP machine at bedside. CNA 14 stated Resident 161 was able to remove the CPAP mask and placed in a clear plastic bag inside the drawer. CNA 14 stated Resident 161 cleaned her own CPAP machine. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/24 at 0827 hours, an interview and concurrent medical record review was conducted with RN 2 for Resident 161. RN 2 verified Resident 161's use of the CPAP machine at bedside. RN 2 was asked for the physician's order for the use and care of the CPAP machine at bedside for Resident 161. RN 2 verified there was no physician's order for the use and care of the CPAP machine at bedside. On 8/19/24 at 1508 hours, an interview and concurrent medical record review was conducted with the DON for Resident 161. The DON was informed of the above findings and verified the findings. Cross references to F641, example #4 and F656, example #3. 48882 6. On 8/13/24 at 1104 hours, Resident 46 was observed lying in bed and receiving supplemental oxygen at 3 liters per minute via nasal cannula. Medical record review for Resident 46 was initiated on 8/12/24. Resident 46 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 46's Order Summary Report for August 2024 showed a physician's order dated 11/1/23, to continuously administer oxygen at 2 liters per minute via nasal cannula every shift for acute and chronic respiratory failure. On 8/14/24 at 0844 hours, Resident 46 was observed in bed receiving supplemental oxygen at 3 liters per minute via nasal cannula. When asked about Resident 46's oxygen, Family Member 2 stated Resident 46 was receiving 3 liters of oxygen via nasal cannula. On 8/14/24 at 1042 hours, an interview and concurrent medical record review for Resident 46 was conducted with LVN 4. LVN 4 was asked how much oxygen Resident 46 was receiving. LVN 4 stated Resident 46 should be on 2 liters per minute of oxygen via nasal cannula. An interview and concurrent observation of Resident 46 was conducted with LVN 4. LVN 4 verified the above findings and stated the oxygen should be set at 2 liters per minute as ordered by the physician. Resident 46's responsible party was at bedside and stated Resident 46's oxygen had always been set at 3 liters per minute. On 8/19/24 at 1515 hours, an interview as conducted with the DON. The DON stated the oxygen should be administered to the residents as ordered by the physician. The DON further stated if the residents were administered more oxygen than prescribed, there may be the risk of over oxygenation which may lead to negative resident outcomes. The DON was informed and acknowledged the above findings. 43119 7. Review of the facility's P&P titled Oxygen Administration revised 2/2024 showed to verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. On 8/12/24 at 0853 hours, during the initial tour, Resident 53 was observed lying in bed with HOB (head of bed)elevated and oxygen on via nasal cannula which was attached to the oxygen machine concentrator setting at 4 liters per minute. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/24 at 0840 hours, during an observation, Resident 53 was observed lying in bed with oxygen on via nasal cannula which was attached to the oxygen machine concentrator setting at 3.5 liters per minute. Medical record review for Resident 53 was initiated on 8/15/24. Resident 53 was admitted to the facility on [DATE]. Review of Resident 53's Order Summary Report dated August 2024 showed a physician's order dated 3/11/24, for oxygen administration at 2 liters per minute via nasal cannula continuously every shift and a physician's order dated 8/12/24, for oxygen administration at 2 liters per minute via nasal cannula as needed for SOB (shortnes of breath) or oxygen saturation <93% for diagnosis of asthma. Review of Resident 53's care plan showed the resident had oxygen therapy related to respiratory illness (asthma) and an intervention dated 11/13/23, was for oxygen at 2-3 liters per minute via nasal cannula as needed for SOB or oxygen saturation level <93%. On 8/15/24 at 1332 hours, an observation and concurrent interview was conducted with LVN 9. LVN 9 verified the oxygen machine concentrator was set at 4.5 liters per minute and the physician's order for the oxygen was to administer at 2 liters per minute continuously for Resident 53. On 8/19/24 at 1604 hours, the DON was informed and verified the above findings.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure appropriate pain management for two of three final sampled residents (Residents 13 and 824) reviewed for pain management. * The facility failed to accurately document monitoring of highest level of pain and failed to administer pain medication according to the physician's order for Resident 824. * The facility failed to administer pain medication according to the physicians' orders for Residents 13. These failures put Residents 13 and 824 at risk for ineffective pain management. Findings: Review of the facility's P&P titled Pain Assessment and Management revised 10/22 showed the pain management program is based on appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. Pharmacological interventions (i.e. analgesics) may be prescribed to manage pain, however they do not usually address the cause of pain and can have adverse effects on residents (e.g., drowsiness, increased risk of falling; loss of appetite). When opioids are used for pain management, the resident is monitored for medication effectiveness, adverse effects, and potential overdose. The medication regimen is implemented as ordered. Results of the interventions are documented and communicated directly to the provider when appropriate. Further review of the facility's P&P showed to monitor the resident's pain and consequences of pain at least each shift for acute pain or significant levels of chronic pain and at least weekly in stable chronic pain. 1. On 8/13/24 at 1430 hours, an interview was conducted with Resident 824. Resident 824 stated she had pain in her neck and legs and the facility was administering Norco (opioid, narcotic pain medication) for her pain. Medical record review for Resident 824 was initiated on 8/12/24. Resident 824 was admitted to the facility on [DATE]. Review of Resident 824's H&P examination dated 8/12/24, under the Assessment and Plan section, showed Resident 824 had back pain and to continue pain management with Norco oral tablet 10-325 mg one tablet by mouth every six hours as needed for severe pain, level 8-10 (on a pain scale 0-10 with 0= no pain and 10=worst pain). Review of Resident 824's Order Summary Report for August 2024 showed the following physician's orders dated 8/9/24: - to monitor for the highest pain level on a scale of 0 to 10 (on a 0 to 10 pain scale, 0 = no pain and 10 = worst pain) every shift, (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- to administer Norco 10-325 mg one tablet by mouth every six hours as needed for severe pain (8-10), - to administer Tylenol (an analgesic) 325 mg one tablet by mouth every four hours as needed for mild pain (1-3), - to administer Tylenol 325 mg, two tablets by mouth every four hours as needed for moderate pain (4-7), not to exceed 3000 mg in 24 hours from all sources. Review of Resident 824's MAR for August 2024 showed Resident 824 was administered Norco 10-325 mg one tablet by mouth every six hours as needed for severe pain (8-10) on the following dates and times, for the following pain levels: - on 8/12/24 at 1640 and 2336 hours, a pain level of 8. - on 8/13/24 at 1041 hours, a pain level of 0; and at 1754 hours, a pain level of 7. Further review of Resident 824's MAR for August 2024 showed the following documented entries for the monitoring of Resident 824's highest pain level, for every shift: - on 8/12/24, a pain level of 0 was documented on all shifts (0700 to 1500 hours, 1500-2300 hours, and 2300-0700 hours shifts) - on 8/13/24, a pain level of 0 was documented on all shifts. On 8/14/24 at 1401 hours, an interview and concurrent record review for Resident 824 was conducted with RN 1. RN 1 verified on 8/13/24 at 1041 hours, she administered Norco 10-325 mg one tablet by mouth to Resident 824. RN 1 verified the pain level was documented as 0. RN 1 also verified Norco 10-325 mg was administered on 8/13/24 at 1754 hours, for a pain level of 7. When asked, RN 1 stated the physician's order for Norco 10-325 mg was for severe pain level between 8 to 10. On 8/14/24 at 1455 hours, a follow-up interview was conducted with RN 1. RN 1 stated she had incorrectly documented Resident 824's pain in the MAR on 8/13/24 at 1041 hours. On 8/15/24 at 1419 hours, an interview and concurrent medical record review for Resident 824 was conducted with the DON. The DON verified the above findings and stated documentation should be accurate to reflect the resident's current condition. The DON further stated the licensed nurses were expected to administer the pain medication as ordered by the physician for the indicated pain level reported by the resident. The DON stated if the pain medications were administered for a pain level outside of the physician's order, the nurse was expected to contact the physician and obtain an order and document in the progress notes. Concurrent record review of Resident 824's Progress Notes was conducted with the DON. The DON verified there were no documentation in Resident 824's medical record to show the nurse contacted the physician to obtain an order to administer Norco 10-325 mg for a pain level of 7 on 8/13/24. The DON was informed and acknowledged the above findings. 39453 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Medical record review for Resident 13 was initiated on 8/12/24. Resident 13 was admitted to the facility on [DATE]. Review of Resident 13"s Order Summary Report dated 8/13/24, showed the following physician's order dated 5/10/24, to administer Tylenol (over the counter pain medication) 325 mg one tablets by mouth every four hours as needed for mild pain, levels of 1-3. Review of Resident 13's MAR for July 2024 showed Resident 13 was administered the Tylenol 325 mg medication on the following dates and times when the resident's pain level was not within the levels of 1-3 as ordered: - On 7/5/24 at 0950 hours, Resident 13 was documented with a pain level of 0. - On 7/12/24 at 0922 hours, Resident 13 was documented with a pain level of 0. - On 7/14/24 at 1315 hours, Resident 13 was documented with a pain level of 0. - On 7/15/24 at 0846 hours, Resident 13 was documented with a pain level of 0. - On 7/18/24 at 0958 hours, Resident 13 was documented with a pain level of 0. - On 7/24/24 at 1726 hours, Resident 13 was documented with a pain level of 4. - On 7/26/24 at 0010 hours, Resident 13 was documented with a pain level of 4. Further review of Resident 13's medical record failed to show a pain medication was prescribed for pain levels above 3. On 8/15/24 at 0842 hours, an interview and concurrent medical record review for Resident 13 was conducted with the DON. The DON was informed and verified the above findings.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on interview, and medical record review, the facility failed to accurately administer the midodrine (for low blood pressure medication) medication during the dialysis (a process of removing excess water solutes and toxins from the blood in people whose kidneys can no longer perform these functions naturally) days for one of two sampled residents (Resident 128) reviewed for dialysis care. In addition, the facility failed to monitor the orthostatic hypotension (blood pressure drops when the resident was standing and sitting down) blood pressure accurately related to the hypotensive medication use. These failures posed the risk for medical complications for Resident 128 on the scheduled dialysis days. Findings: a. On 8/19/24 at 1330 hours, an interview was conducted with Resident 128. Resident 128 stated the dialysis schedule days were Tuesdays, Thursdays, and Saturdays at 0930 hours, in the morning. Resident 128 stated he took his medications before going to dialysis. Medical record review for Resident 128 was initiated on 8/19/24. Resident 128 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 128's H&P examination dated 8/5/24, showed Resident 128 had the capacity to make medical decisions. Review of Resident 128's Order Summary Report dated 8/12/24, showed the following physician's orders: - dated 8/2/24, for dialysis schedule on Tuesdays, Thursdays, and Saturdays with a chair time at 1015 hours. - dated 8/2/24, to administer midodrine Hcl 10 mg tablet by mouth three times a day for hypotension and to hold if systolic (highest number on blood pressure reading) blood pressure more than 140 mmHg. Review of Resident 128's MAR for August 2024 showed the Midodrine medication dose scheduled for 1300 hours was administered to Resident 128 while the resident was not in the facility for dialysis on the following days: - On 8/3, 8/6, 8/8, 8/13, 8/15, and 8/17/24 at 1300 hours. b. Review of Resident 128's MAR for July 2024 showed the orthostatic blood pressures (sitting and lying) were scheduled to be monitored every day. However, the blood pressure readings for both positions (lying and sitting) were the same as follows: - On 7/1/24, the blood pressure readings were 137/77 mmHg for the sitting position and 137/77 mmHg for the lying position. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 7/2/24, the blood pressure readings were 129/79 mmHg for the sitting position and 129/79 mmHg for the lying position. - On 7/3/24, the blood pressure readings were 140/87 mmHg for the sitting position and 140/87 mmHg for the lying position. - On 7/4/24, the blood pressure readings were 107/69 mmHg for the sitting position and 107/69 mmHg for the lying position. - On 7/6/24, the blood pressure readings were 126/76 mmHg for the sitting position and 126/76 mmHg for the lying position. - On 7/7/24, the blood pressure readings were 127/73 mmHg for the sitting position and 127/73 mmHg for the lying position. - On 7/8/24, the blood pressure readings were 100/66 mmHg for the sitting position and 100/66 mmHg for the lying position. - On 7/9/24, the blood pressure readings were 132/77 mmHg for the sitting position and 132/77 mmHg for the lying position. - On 7/10/24, the blood pressure readings were 111/63 mmHg for the sitting position and 111/63 mmHg for the lying position. - On 7/13/24, the blood pressure readings were 127/72 mmHg for the sitting position and 127/72 mmHg for the lying position. - On 7/18/24, the blood pressure readings were 118/64 mmHg for the sitting position and 118/64 mmHg for the lying position. - On 7/19/24, the blood pressure readings were 121/68 mmHg for the sitting position and 121/68 mmHg for the lying position. - On 7/20/24, the blood pressure readings were 118/89 mmHg for the sitting position and 118/89 mmHg for the lying position. - On 7/22/24, the blood pressure readings were 103/66 mmHg for the sitting position and 103/66 mmHg for the lying position. - On 7/24/24, the blood pressure readings were 100/61 mmHg for the sitting position and 100/61 mmHg for the lying position. (continued on next page)

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Laguna Hills Health and Rehabilitation Center	24452 Health Center Drive Laguna Hills, CA 92653

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/19/24 at 1332 hours, an interview and concurrent medical record review for Resident 128 was conducted with LVN 12. LVN 12 verified Resident 128 went to the scheduled dialysis days on Tuesdays, Thursdays, and Saturdays at 0930 hours. LVN 12 verified the licensed nurses administered medication to Resident 128 on dialysis days. LVN 12 verified Resident 128 returned to the facility around 1430 to 1500 hours, from dialysis. LVN 12 was asked to review the MAR for August 2024. LVN 12 verified the 1300 hour dose for Midodrine medication was administered to the resident because the licensed nurses signed their initials on the days when Resident 128 was not in the facility for dialysis. LVN 12 was asked about the orthostatic blood pressure monitoring of Resident 128. LVN 12 reviewed the MAR for July 2024 and verified the orthostatic blood pressure monitoring were inaccurate because of the same blood pressure readings for both positions (sitting and lying). On 8/19/24 at 1605 hours, an interview and concurrent medical record review for Resident 128 was conducted with the DON. The DON was informed and verified the above findings.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the narcotic medication count matched the narcotic count sheet, disposed narcotic count sheets were signed by two license nurses, and the blood pressure medication for Resident 32 had monitoring parameters as evidence by: * The facility failed to ensure the narcotic medication count matched the narcotic count sheet for four out of 14 final nonsampled residents (Residents 43, A, B, and C). * The facility failed to ensure the disposed narcotic count sheets were signed by two license nurses as per the facility's P&P for one of 35 final sampled residents (Resident 128) and three of 14 final nonsampled residents (Residents 76, 165, and 475). * The facility failed to ensure the metoprolol tartrate (blood pressure medication) medication for Resident 32 had parameters to hold the medication. These failures had the potential to result in medication diversion (the illegal use or distribution of a prescription medication that was not originally intended by the prescriber) and unsafe handling of the medications. Findings: Review of the facility's P&P titled IIA5: Controlled Medications revised 8/2014 showed medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility, in accordance with federal and state laws and regulations. The P&P further showed the following: C. When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the Medication Administration Record (MAR): 1. Date and time of administration. 2. Amount administered. 3. Signature of the nurse administering the dos on the accountability record at the time the medication is removed form the supply. 4. Initials of the nursing administering the dose on the MAR after the medication is administered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D. When a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. It must be destroyed according to facility policy in the presence of two licensed nurses and the disposal documented on the accountability record on the line representing that dose. The same process applies to the disposal of unused partial tablets and unused position of single dose samples. According to the DEA, oxycodone (pain medication) and hydrocodone combination products including Hydrocodone-Acetaminophen (pain medication) is categorized as a Schedule II narcotic. The DEA labels Scheduled II drugs as having a high potential for abuse and considered dangerous. Furthermore, the DEA defines benzodiazepines as depressants that produce sedation and hypnosis, relieve anxiety and muscle spasms, and reduce seizures including medications lorazepam (anti-anxiety medication), alprazolam (anti-anxiety medication), and temazepam (hypnotic medication). The DEA showed benzodiazepines can cause extreme drowsiness, confusion, decreased reflexes, respiratory depression, and impaired coordination. 1. On 8/13/24 at 1140 hours, medical records reviews and concurrent interview with the IP was conducted. a. The IP verified Resident A's physician order dated 8/9/24, showed to administer alprazolam 0.25 mg to give one tablet by mouth every eight hours as needed. The IP verified Resident A's narcotic count sheet showed there was 19 alprazolam tablets available; however, the medication bubblepack showed 18 alprazolam tablets remained. b. The IP verified Resident C's physician orders dated 8/6/24, showed to administer Pregabalin 50 mg (pain medication) one capsule by mouth three times a day. The IP verified Resident C's narcotic count sheet showed there was 30 Pregabalin capsules available; however, the medication bubblepack showed 29 capsules remained. On 8/13/24 at 1539 hours, medical record review and concurrent interview with the IP was conducted. c. The IP verified Resident B's physician orders dated 8/3/24, showed to administer hydrocodone/acetaminophen (Norco) 5-325 mg (pain medication) give one tablet by mouth every four hours as needed. The IP verified Resident B's narcotic count sheet showed there was 19 Norco 5-325 mg tablets available; however, the medication packet showed 18 tablets remained. d. The IP verified Resident 43's physician's order dated 8/5/24, showed to administer Lacosamide (seizure medication) give one tablet by mouth two times a day. The IP verified Resident 43's narcotic count sheet showed there was 15 Lacosamide tablets available; however, the medication packet showed 14 tablets remained. The IP stated the nurses should sign the narcotic count sheets once the residents receive the narcotic mediation to ensure the accountability of the narcotic medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 8/15/24 at 1232 hours, a facility document review and concurrent interview with the DON was conducted in the DON's office. The following facility documents were reviewed: - Resident 128's narcotic count sheet for Norco 5-325 mg, dated 4/24/24; - Resident 76's narcotic count sheet for lorazepam 0.5 mg, dated 8/14/24; - Resident 165's narcotic count sheet for Norco 5-325 mg, dated 8/14/24; and - Resident 475's narcotic count sheet for temazepam 15 mg, dated 8/14/24. The DON verified the above narcotic count sheets showed no documented evidence of two license nurses' signatures as per the facility's P&P. The DON stated there should have been two license nurses' signatures to ensure the narcotic medication count was accurate and verified by two license nurses. 3. Medical record review for Resident 32 was initiated on 8/12/24. Resident 32 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 32's quarterly MDS dated [DATE], showed Resident 32 had a BIMS score of 00 which meant the resident's cognition was severely impaired. Review of Resident 32's physician orders for August 2024 showed to administer metoprolol tartrate 50 mg (blood pressure medication) give one tab by GT at 0900 hours. On 8/15/24 at 1553 hours, an interview and concurrent medical record review with LVN 9 was conducted. LVN 9 verified Resident 32's physician's order included metoprolol tartrate medication. LVN 9 verified the metoprolol tartrate order did not include parameters to hold the medication for low blood pressure or heart rate. Moreover, LVN 9 stated metoprolol tartrate should have parameters to ensure the medication was not administered if the heart rate and blood pressure outside of the normal range since the medication can further lower the blood pressure and heart rate. On 8/19/24 at 1350 hours, an interview with the Administrator and DON was conducted. The DON stated he expected the licensed nurses to sign the narcotic count sheet once the narcotic medication was administered. The DON further stated signing the narcotic count sheet ensured narcotic medications were accounted and avoid narcotic diversion. The DON also stated the blood pressure medication metoprolol tartrate should have blood pressure and heart rate parameters. The Administrator and DON acknowledged all above findings.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 39683 Based on interview, medical record review, and facility document review, the facility failed to act upon the Consultant Pharmacist's recommendations timely for one of five residents reviewed for unnecessary medications (Resident 25.) * Resident 25's Consultant Pharmacist's recommendations were not followed up on timely for June and July 2024. This failure had the potential for not addressing the care needs for this resident. Findings: Medical record review for Resident 25 was initiated on 8/12/24. Resident 25 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 25's H&P examination dated 2/6/26, failed to show documentation the resident had a psychiatric diagnosis. Review of Resident 25's Order Summary Report dated 8/14/24, showed a physician's order dated 6/17/24, for risperidone (an antipsychotic medication) 0.25 mg for psychotic features manifested by angry outbursts. Review of the Consultant Pharmacist's Medication Regimen Review for the period from 6/1/23 through 6/26/24, showed the recommendation as follows: Resident 25's order for risperidone had an unapproved/inappropriate diagnosis and psychotic features was not a diagnosis. Please clarify the diagnosis with the physician. Review of the Consultant Pharmacist's Medication Regimen Review for the period from 7/1/23 through 7/23/24, showed the recommendation as follows: Resident 25's order for risperidone had an unapproved/inappropriate diagnosis and psychotic features was not a diagnosis. Please clarify the diagnosis with the physician. On 8/15/24 at 1401 hours, an interview and concurrent record review were conducted with the ADON. The ADON reviewed Resident 25's medical record and the Resident 25's Consultant Pharmacist's Medication Regimen Review recommendations for June and July 2024 and verified the facility failed to follow-up on the pharmacist's recommendations. On 8/19/24 at 1257 hours, the ADON stated they were unable to find an appropriate diagnosis for Resident 25's risperidone use. On 8/19/24 at 1309 hours, and interview was conducted with the DON. The DON stated for the pharmacist's monthly drug regimen review findings, once the facility received the pharmacist's report, the nursing staff would call the physician to follow-up on the pharmacist's recommendations within seven days.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on observation, interview, and medical record review, the facility failed to ensure two of 35 final sampled residents (Residents 13 and 46) were free from unnecessary drugs. * Resident 46 was administered carvedilol (blood pressure medication) when the resident's blood pressure or heart rate was below the parameters prescribed by the physician. * Resident 13 was administered carvedilol (medication to treat high blood pressure) on numerous occasions when Resident13's systolic blood pressure was below the parameter prescribed the physician. These failures had the potential for the residents to receive unnecessary medications and develop significant side effects such as bradycardia (abnormally low heart rate) and/or hypotension (abnormally low blood pressure). Findings: Review of Lexicomp, an online reference for clinical drug information showed adverse effects of carvedilol included bradycardia and hypotension. 1. Medical record review for Resident 46 was initiated on 8/12/24. Resident 46 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 46's Order Summary Report for August 2024 showed a physician's order dated 2/14/23, to administer carvedilol 3.125 mg one tablet via GT two times a day for hypertension (high blood pressure). The physician's order showed to hold thecarvedilol if the systolic blood pressure (the top reading in a blood pressure measurement) less than 110 mmHg or if the heart rate less than 65 bpm (beats per minute). Review of Resident 46's MAR for August 2024 showed Resident 46 was administered carvedilol 3.125 mg when Resident 46's blood pressure or heart rate was below the parameters prescribed by the physician on the following dates: - on 8/2/24 at 0900 hours, Resident 46's systolic blood pressure was 98 mmHg, - on 8/10/24 at 1700 hours, Resident 46's systolic blood pressure was 106 mmHg, - on 8/11/24 at 0900 hours, Resident' 46's heart rate was 64 bpm, - on 8/12/24 0900 hours, Resident' 46's heart rate was 62 bpm, - on 8/13/24 0900 hours, Resident' 46's heart rate was 62 bpm, and - on 8/14/24 0900 hours, Resident' 46's heart rate was 62 bpm. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/24 at 1042 hours, an interview and concurrent medical record review for Resident 46 was conducted with LVN 4. LVN 4 verified the above findings. On 8/19/24 at 1515 hours, an interview was conducted with the DON. The DON stated all the medications should be administered to the residents as ordered by the physician. The DON further stated he expected the staff to follow the parameters for the blood pressure and heart rate when administering the blood pressure medications due to the potential risk of hypotension or bradycardia (slow heart rate). The DON was informed and acknowledged the above findings. 39453 2. Medical record review for Resident 13 was initiated on 4/9/24. Resident 13 was admitted to the facility on [DATE]. Review of Resident 13's Order Summary Report showed a physician's order dated 4/9/24, to administer carvedilol 6.25 mg one tablet by mouth two times a day; and to hold if the systolic blood pressure less than 110 mmHg. Review of Resident 13's MAR for July and August 2024 showed Resident 13 was administered the carvedilol medication when the resident's systolic blood pressure was less than mmHg as follows: - On 7/1/24 at 1700 hours, a blood pressure of 101/50 mmHg; and - On 8/3/24 at 1700 hours, a blood pressure of 100/51 mmHg. On 8/15/24 at 0842 hours, an interview and concurrent medical record review for Resident 13 was conducted with the DON. The DON was informed and verified the above findings.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683 Based on interview and medical record review, the facility failed to ensure an appropriate diagnosis for the use of the psychotropic medication for one of five residents reviewed for unnecessary medications (Resident 25). * Resident 25's order for risperidone (an anti-psychotic medication) had an unapproved/inappropriate diagnosis. This failure had the risk of inappropriate psychotropic medication use for the resident. Findings: Medical record review for Resident 25 was initiated on 8/12/24. Resident 25 was admitted to the facility on [DATE], and readmitted [DATE]. Resident 25 was [AGE] years old. Review of Resident 25's H& P examination dated 2/6/26, failed to show the resident had a psychiatric diagnosis. Resident 25's medical record failed to show an approved diagnosis for the risperidone medication use. Review of Resident 25's Order Summary Report dated 8/14/24, showed a physician's order dated 6/17/24, for risperidone (an antipsychotic medication) 0.25 mg for psychotic features manifested by angry outbursts. Review of the Consultant Pharmacist's Medication Regimen Review for the period from 6/1/23 through 6/26/24, showed Resident 25's order for risperidone has an unapproved/inappropriate diagnosis and psychotic features was not a diagnosis. On 8/15/24 at 1401 hours, an interview and concurrent record review were conducted with the ADON. The ADON reviewed Resident 25's medical record and verified the risperidone did not have an appropriate diagnosis for the use of this medication.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474 Based on observation, interview, medical record review, and the facility P&P, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 6.06%. * The facility failed to ensure LVN 10 administered Resident 4's calcium-vitamin D3 600-12.5 mg-mcg (vitamin supplement) and sennosides 8.6 mg (stool softener medication) as ordered. This failure had the potential to cause negative outcome for Resident 4. Findings: Review of the facility's P&P titled Medication and Treatment Orders revised 7/2016 showed drugs and biologicals that are required to be refilled must be reordered form the issuing pharmacy not less than three days prior to the last dosage being administered to ensure that refills are readily available. Medical record review for Resident 4 was initiated on 8/12/24. Resident 4 was admitted to the facility on [DATE], and readmitted back to the facility on [DATE]. Review of Resident 4's quarterly MDS dated [DATE], showed Resident 4 had a BIMS score of 8 which meant the resident's cognition was moderately impaired. Review of Resident 4's physician's orders dated August 2024 showed the following: - Calcium-Vit D3 600-12.5 mg-mcg one capsule by mouth QD (daily), an order date of 9/10/23. - Sennosides 8.6mg 1 tab by mouth BID (two times a day), an order date of 6/21/23. On 8/14/24 at 0945 hours, a medication administration observation was conducted with LVN 10 for Resident 4. LVN 10 did not administer calcium-vitamin D3 600-12.5 mg-mcg and sennosides 8.6 mg as ordered. On 8/14/24 at 1032 hours, an interview was conducted with LVN 10. LVN 10 verified calcium-vitamin D3 and sennoside medications were not administered as ordered. LVN 10 further stated the facility did not have the medications available and would have to order more from pharmacy. On 8/19/24 at 1350 hours, an interview was conducted with the Administrator and DON. The Administrator and DON acknowledged above findings.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474 Based on observation, interview, and facility P&P review, the facility failed to store the drugs, biologicals, and medical supplies in a safe manner as evidenced by the following: * The facility failed to ensure one of 14 medications for Resident 32 was not left unattended on top of the medication cart. * The facility failed to dispose of the expired medications inside Medication Room C. * The facility failed to ensure the oral and external medications were stored separately for Resident 159. * The facility failed to ensure the unlabeled medications were not kept in the medication cart, OTC medications were properly labeled with the date opened, and expired medications and opened medical supplies were properly disposed. * The facility failed to ensure the medication destruction container was not overfilled and properly disposed of medications and biologicals. * The facility failed to ensure the medication was not left at Resident 475's bedside. These failures had the potential to cause unsafe handling and storage of the residents' medications. Findings: Review of the facility's P&P titled ID1: Medication Storage in the Facility dated 4/2008 showed medication and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The P&P further showed the following: B. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized. Only licensed nurses, pharmacy personnel, and those lawfully authorized are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attend by persons with authorized access. C. Orally administered medications are kept separate from externally used medications such as suppositories, liquids, and lotions. M. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, spoiled or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. N. Medication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Medical record review for Resident 32 was initiated on 8/12/24. Resident 32 was admitted to the facility on [DATE], and readmitted back to the facility on [DATE]. Review of Resident 32's quarterly MDS dated [DATE], showed Resident 32 had a BIMS score of 00 which meant the resident's cognition was severely impaired. Review of Resident 32's physician's orders dated August 2024 showed the following: - dated 812/23, to administer ipratropium bromide (medication used to open the air ways in the lungs) inhalation solution 0.02 % 2.5 ml inhale orally via nebulizer four times a day for respiratory failure. On 8/14/24 at 0902 hours, an observation and concurrent interview was conducted with LVN 9. LVN 9 was observed leaving Resident 32's ipratropium bromide one unit dose vial unattended on top of the medication cart. LVN 9 verified he left Resident 32's medication on top of the medication cart unattended. LVN 9 stated medications should not be left unattended to ensure unauthorized personnel, including other residents had no access to the medication and use it. 2. On 8/15/24 at 1319 hours, an observation and concurrent interview was conducted with the IP in Medication Room C. The OTC medication cabinet was observed unlocked and stored one opened bottle of aspirin 325 mg (pain medication) with an opened date of 2/9/24, and had expired on 12/2024. The IP verified the OTC medication cabinet should be locked and only stored new, unopened OTC medications. The IP stated the opened aspirin bottle should not be stored in the OTC medication cabinet. 3. On 8/13/24 at 1049 hours, an observation and concurrent interview was conducted with the IP for Medication Cart 1. One brown paper bag labeled with Resident 159's name was observed with the following oral and external medications stored together. - Three acetaminophen suppository (pain medication). - Five bisacodyl suppository (stool softener medication). - Six tablets of ondansetron (nausea and vomiting medication). - Six tablets of hyoscyamine (muscle cramp medication). The IP stated oral and external medications such as the suppository medications should have been separated. The IP further stated separating oral and external medications prevented medications given through the wrong route. 4. Review of the facility's medication carts and medication storage rooms with the IP showed the following: Medication Cart 1: - One opened bottle of milk of magnesium (laxative and antacid medication) with no open date. - One opened bottle of Pink Bismuth (heartburn medication) with an open date since 2/15/23. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- One opened bottle of guaifenesin liquid (cough medication) with no open date. - One opened bottle of niacin (supplement medication) with no open date, and had expired on 7/2024. - One opened bottle of Florastor (probiotic medication) with no open date. - Six tablets of anti-diarrheal medications with no open date. - One opened bottle of 21st Century A Eye Health (supplement medication) with no open date. - One opened bottle of 21st Century High Potency Slow Release Iron (supplement medication) with no open date. - One opened bottle of Geri-Lanta (antacid medication) with no open date opened. - One opened bottle ClearLax (laxative medication) with no open date. - One opened bottle of iron (supplement medication) with no open date. - One opened bottle of brimonidine 0.2% (eye drop medication) with no open date. - One opened bottle of Timoptic 0.5% (eye drop medication) with no open date. - One opened bottle of naproxen (pain medication) with no open date. - One opened bottle of cetirizine (allergy medication) with no open date. - One opened bottle of melatonin (sleep supplement medication) with no open date. - One opened bottle of of zinc (supplement medication) with no open date. - One opened bottle of magnesium oxide (supplement medication) with no open date opened. Medication Cart 2: - One unidentified and unlabeled white tablet medication found on the top right drawer of the medication cart. - One opened bottle of lactulose (stool softener medication) with no open date. - One opened bottle senna 8.6 (stool softener medication) with no open date. - One opened bottle of ferrous gluconate 240mg (supplement medication) with no open date, and had expired on 5/2024. - One opened bottle of Geri-Tussin DM (cough medication) with no open date. - One opened bottle of fluticasone propionate (nasal spray medication) with no open date. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medication Cart 3: - Five unidentified and unlabeled white tablet medications found on the top left drawer of medication cart. - Eight out of 11 insulin pens (blood sugar medication) with no open date. - One opened bottle of One Daily Multivitamin (supplement medication) with no open date. - One opened bottle of Cayenne Complex 600 mg (supplement medication) with no open date. Medication Cart 5: - 18 povidone-iodine swabstick 10% (antiseptic medication) had expired on 4/2024. - One opened bottle of Hibiclens chlorhexidine gluconate 4.0% (antispectic skin cleanser medication) with no open date opened. Medication Cart 7: - Two suction catheter kits had expired on 7/31/24. Medication Room A: - One opened Negative Pressure Wound Therapy System had expired on 10/20/23. On 8/14/24 at 1345 hours, an observation and concurrent interview was conducted with the IP. The IP verified the above findings. The IP stated the facility should have discarded the expired medications and medical supplies to ensure infection control was maintained. The IP stated the OTC medications should have an open date to maintain the medications' efficacy and the OTC medication cabinet did not store the opened and used OTC medications. The IP further stated the unlabeled medications should not be left in the medication cart and should be discarded. 5. On 8/14/24 at 1328 hours, an observation and concurrent interview was conducted with the IP in Medication Room B. One destruction bin was observed filled past the fill-line and observed with the following: - One insulin pen - Three OTC bottles - One nasal spray - Six unidentified silver packages (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The IP stated the six unidentified silver packages were breathing treatment medications. The IP stated the destruction bin should only have crushed and diluted pills and liquids; however, the IP verified the above findings were inside the destruction bin. Furthermore, the IP also verified the medications inside the destruction bin overflowed past the recommended fill-line. The IP stated the destruction bins should not have whole bottles, insulin pens, or packages in the destruction bin. On 8/15/24 at 1232 hours, an interview was conducted with the DON. The DON stated the medications placed in the destruction bin should be crushed and diluted to ensure the medications would not be taken and used. The DON stated the destruction bin was incinerated and should not have packages for breathing treatments, insulin pens, and whole medication bottle placed inside of the bin. On 8/19/24 at 1350 hours, an interview was conducted with the Administrator and DON. The Administrator and DON acknowledged all the above findings. 39670 6. On 8/12/24 at 1314 hours, during the initial tour of the facility, Resident 475's overbed table was observed to have a Nasal Spray Phenylephrine Hcl 1% (nasal decongestant) bottle on top. On 8/12/24 at 1344 hours, an observation and concurrent interview for Resident 475 was conducted with RN 2. RN 2 verified the nasal spray medication at the resident's bedside had no label of the resident name. RN 2 was asked if there was a physician's order for the medication and if Resident 475 was able to self-administer her own medication. RN 2 reviewed the medical record and verified there were no physician's orders for Resident 475's medication and self-administration of her own medication. On 8/19/24 at 1057 hours, an interview was conducted with the DON. The DON was informed of the above finding and verified the finding.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 39856 Based on interview and facility document review, the facility failed to ensure the DSS met the educational requirements for the position. This failure to employ staff with the skills and educational requirements to effectively implement departmental processes in accordance with standards of practice, had the potential to jeopardize the health and well-being of the 166 residents who received food prepared in the kitchen. Findings: Review of the facility's job description for the Dietary Supervisor signed and dated by the DSS on 3/3/24, showed education/licensure requirements is completion of accredited course in dietetic training approved by the Academy of Nutrition and Dietetics (AND) (formerly known as the American Dietetic Association). Review of the facility matrix showed 166 of 172 residents consumed food prepared in the kitchen. On 8/12/24 at 0850 hours, an interview was conducted with the DSS. The DSS stated he was currently enrolled in an online course to obtain a Certified Dietary Manager certificate (an approved course in dietetic training). On 8/12/24 at 1653 hours, a telephone interview was conducted with the VPIS. The VPIS stated she was responsible for multiple departments of which food service was one. The VPIS stated the DSS had his degree in dietetic training. On 8/13/24 at 0807 hours, an additional interview was conducted with the DSS. The DSS verified he did not have any formal education or certificate in dietetic training approved by the AND. On 8/14/24 at 0918 hours, an interview was conducted with the Administrator. The job description for the DSS was reviewed with the Administrator. The Administrator verified the job description for the DSS position required an accredited course in dietetic training. The Administrator verified the DSS did not possess the appropriate training per the DSS job description.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 39856 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure one of 20 kitchen employee (DA 1) was competent in the position related duties when the manual ware washing procedure was not followed. This failure had the potential for food preparation equipment, dishware and utensils to not be cleaned and sanitized correctly. Findings: According to the USDA Food Code 2022 Section 4-501.19 Manual Ware washing Equipment, Wash Solution Temperature. The temperature of the wash solution in manual shall be maintained at not less than 110 degrees Fahrenheit (F). Review of the facility's P&P titled Guidelines for the Food and Nutrition Services Department revised 2/4/2020, under the Manual Washing section, showed in part, for the two compartment sink method as follows: 1. Fill sink #1 to the marked water line with clean hot water then add detergent according to the chemical vendor instructions. 2. Fill sink #2 to the mark line with clean hot water. 3. Wash service ware thoroughly in the hot detergent water, rinse in the clear water sink #2. 4. Drain sink #2, refill with appropriate amounts of sanitizing solution and water. 5. Use the provided test strips to test the concentration of the sanitizing solution and record on the sanitizing sink log . Review of the skills performance checklist completed by the DSS on 6/5/24, showed DA 1 met the skills for sanitation of equipment and utensils. Review of the facility's in-service on manual dishwashing, dated 7/5/24, showed DA 1 attended the training. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/13/24 at 1058 hours, an observation of the manual ware washing procedure and concurrent interview was conducted with DA 1 using the DSS as a translator. The manual ware washing sink was comprised of two sinks; the first sink contained soapy wash water and the second sink contained sanitizer. DA 1 was asked to demonstrate the manual ware washing procedure using the two-sink method. DA 1 stated he washed the dishes in the wash water. DA 1 was asked what the temperature of the wash water should be. DA 1 stated the water should be hot. DA 1 was asked how he measured the wash water temperature. DA 1 stated he used a thermometer but did not have a thermometer. DA 1 was asked if he did not have a thermometer how he measured the wash water temperature. DA 1 stated he felt the water with his hands and demonstrated by putting his hand in the wash water then stated the wash water should be 104-106 degrees F. Using the surveyor thermometer the wash water temperature measured 107.2 degrees F. A poster above the manual dish sink showed the wash water temperature should be 110 degrees F. DA 1 was then asked how he rinsed the dishes. DA 1 stated he used the sprayer to rinse the dishes. DA 1 stated he used the second sink to sanitize the dishes. The DSS stated the county had approved using the sprayer to rinse the dishes. On 8/19/24 at 0830 hours, an interview was conducted with the DSS. The DSS was asked how he measured the competency of the employees during the in-service given on 7/5/24, regarding manual ware washing. The DSS verified he did not check the competency of the employees during the in-service on manual ware washing. The DSS was asked about the county approving the sprayer used to rinse dishes in the manual ware washing sink. The DSS stated the county did not give anything in writing which approved using the sprayer to rinse the dishes, only that the county did not mention it was a concern.

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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. 48853 Based on observation, interview, and facility document review, the facility failed to ensure the menus were followed for the residents who consumed food provided by the kitchen. * The puree recipe was not followed for puree chicken. * There were no recipes for the daily soup. These deficient practices had the potential to place the residents at risk of compromised nutritional status as a result of the food not meeting their nutritional needs. Findings: Review of the facility matrix showed 166 of 172 residents consumed food prepared in the kitchen. 1. Review of the facility's P&P titled Menus revised on 10/2017, showed menus are developed and prepared to meet resident choices including religious, cultural, and ethnic needs while following established national guidelines for nutritional adequacy. Review of the facility document titled Herb Baked Chicken Breast Fillet Recipe # 8218, Week three Tuesday noon meal, undated, showed herb baked chicken 19 each, thickener 3/4 cup + 3 1/4 tablespoon, hot liquid, hot water or low sodium broth 3 1/4 cup. Puree: Place cooked portions needed into food processor, process to a fine texture for every five portions needed, Prepare slurry thickener and hot liquid (water or broth); mix well with a wire whip, Add 1/2 of the slurry to the meat. Process for one minute, if too dry, add some more slurry until meat is pudding consistency. On 8/13/24 at 1038 hours, an observation of the puree preparation and concurrent interview was conducted with [NAME] 1. [NAME] 1 stated he was preparing 20 servings of puree chicken. [NAME] 1 was observed to put ten pieces of three oz chicken breast and three ladles of broth and blended in the blender. When asked what type of broth was used, [NAME] 1 stated he used regular broth. He further stated he used one oz of broth base to six cups of water to make the chicken broth for the chicken puree. [NAME] 1 placed the pureed chicken in a steam table pan. [NAME] 1 placed an additional 10 pieces of three oz chicken in the blender and added two ladles of chicken broth and blended to mashed potato consistency. On 8/15/24 at 0954 hours, an interview was conducted with [NAME] 1. [NAME] 1 confirmed he used regular broth, and the facility did not have low sodium broth. On 8/15/24 at 0956 hours, an interview was conducted with the DSS. The DSS verified the facility did not have low sodium broth. 2. Review of the facility document titled Therapeutic Spreadsheet Cycle 2 2024, undated, showed to serve herb baked chicken, garlic rice, brussels sprouts, roll and margarine for lunch meal. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/13/24 at 1129 hours, during the lunch meal tray line observation, lunch trays were observed to have carrot soup. On 8/13/24 at 1135 hours, an interview was conducted with the DSS. The DSS stated soup was not in the menu; however, the soup was offered to all residents daily. The DSS further stated [NAME] 2 was responsible to prepare the soup each day. On 8/13/24 at 1429 hours, an interview was conducted with [NAME] 2. [NAME] 2 stated he cooked different types of soup every day depending on what ingredients were available. [NAME] 2 confirmed the daily soup was not on the menu and stated he did not follow a recipe. On 8/13/24 at 1508 hours, an interview was conducted with the DSS. The DSS confirmed there were no recipes for the daily soup nor was the soup included in the menu or the Therapeutic Spreadsheet.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48853 Based on observation, interview, facility document review and facility P&P review, the facility failed to ensure the food safety and sanitation guidelines were followed when: 1. Food stored in the walk-in refrigerator was not labeled or dated. Additionally, food requiring monitoring of cool down temperatures was not monitored. 2. The food contact surfaces were not clean or in a cleanable condition. 3. The hair restraints were not worn by two of 20 kitchen staff and two non-kitchen staff who entered the kitchen. 4. The water temperature of the manual ware washing sink was less than 110 degrees F. 5. The process for a two-compartment ware washing sink was not followed. 6. The mops was not stored in a sanitary condition. 7. The nonfood contact surfaces of kitchen were not clean. These failures posed the risk for food borne illnesses in highly susceptible resident population of 166 facility residents who received food prepared in the kitchen. Findings: Review of the facility matrix showed 166 of 172 residents consumed food prepared in the kitchen. 1. According to the USDA Food Code 2022, Section 3-501.14 (A) Cooked time/temperature control for safety food shall be cooled: (1) Within two hours from 57 degrees Celcius (135 degrees F) to 21 degrees Celcius (70 degrees F) and (2) Within a total of six hours from 57 degrees Celcius (135 degrees F) to 5 degrees Celcius (41 degrees F) or less. a. Review of the facility document titled Special Cool Down Log undated, showed use for potentially hazardous foods prepared from ingredients at ambient temperature (room temperature) such as canned tuna. The log failed to show documentation of the cool down process for the cooked ground beef. During the initial tour of kitchen on 8/12/24 at 0743 hours, a quarter steam table pan was observed covered with foil in the walk-in refrigerator. The covered pan contained cooked ground beef and was not labeled or dated. On 8/12/24 at 1542 hours, an interview was conducted with the DSS. The DSS stated all food items inside the refrigerator should be labeled and dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/13/24 at 1450 hours, an interview and concurrent facility document review was conducted with [NAME] 2 and the DSS. [NAME] 2 verified the Special Cool Down Log failed to show documentation of the cooked ground beef seen in the walk-in refrigerator was monitored. The DSS confirmed the cooked ground beef had been discarded. b. Review of the facility's P&P titled Labeling and Dating of Food revised 1/2018 showed opened products can be stored in original containers if the container can be closed properly. All products must clearly be labeled with the date when the product was opened. Opened products that cannot be stored in their original containers must be transferred to a plastic re-usable container and covered. Appropriate coverings include plastic-wrap, foil, or tight-fitting lids, the products should be clearly labeled and dated. During the initial kitchen tour on 8/12/24 at 0743 hours, the following was observed in the walk-in refrigerator 1: - sliced meat opened in a plastic bag with no label and no date, - chopped and sliced tomatoes stored on a tray with no cover, no label, and no date; and - personal staff salsa in a yogurt container wrapped with a plastic cover was stored in the walk-in refrigerator 1 with no label and no date. On 8/12/24 at 1542 hours, an interview with the DSS was conducted. The DSS stated all food items in the refrigerator should be covered, labeled, and dated. c. Review of the facility's P&P titled Foods Brought by Family/ Visitors revised December 2021 showed food brought by family/visitors that is left with the resident to consume later will be labeled and stored in a manner that is distinguishable from facility prepared food. On 8/12/24 at 1624 hours, an observation of Refrigerator 3 and concurrent interview with LVN 5 was conducted. A can of Starbucks shot energy was observed open in the freezer without a name and date label. LVN 5 verified the findings. LVN 5 stated foods were stored in the refrigerator for a maximum of three days. 2. Review of the facility's P&P titled Sanitation revised 11/2022 showed, the food service area is maintained in a clean and sanitary manner .all utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks, and chipped areas that may affect their use or proper cleaning. On 8/12/24 at 0743 hours, during the initial tour of kitchen, the following was observed: - food preparation area 1 was observed with crumbs, two dirty knives, a wire whisk, and a label gun. - food preparation area 2 was observed with a pan covered with foil dated 8/12/24 and a box of clean gloves on a soiled cutting board. The sink had a soiled pot, a soiled wire whisk, and a plastic container filled with soiled water and kitchen utensils. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/12/24 at 0910 hours, an interview was conducted with the DSS. The DSS verified food preparation areas 1 and 2 were not clean. The DSS added the food preparation areas should have been cleaned right after the food was prepared and the sink should not contain soiled pots or any kitchen utensils. a. On 8/12/24 at 0743 hours, during the initial tour of kitchen, two of two juice dispenser nozzles attached to the beverage dispensing system were observed hanging from the food preparation counter with contamination potential. The nozzle dispensers were not stored in the nozzle dispenser storage receptacle. On 8/12/24 at 0850 hours, an observation and concurrent interview was conducted with the DSS. The DSS stated the juice nozzles should have been stored in nozzle dispenser storage receptacle when not in use. The DSS placed the two juice nozzles dispenser in the storage receptacle. b. According to the USDA Food Code 2022, Section 4-501.12, Cutting Surfaces, showed surfaces such as cutting blocks that are subject to scratching and scoring shall be resurfaced if they can no longer be effectively cleaned and sanitized, or discarded if they are not capable of being resurfaced. On 8/12/24 at 0749 hours, four green cutting boards were observed to be heavily marred with knife marks. On 8/12/24 at 0850 hours, an interview was conducted with the DSS. The DSS agreed the four cutting boards were heavily marred and stated the cutting boards will be replaced. 3. According to the USDA Food Code 2022, Section 2-402.11 Effectiveness (A), Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils. Review of the facility's P&P titled Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices revised 11/2022 showed hair nets or caps and/ or beard restraints are worn when cooking, preparing, or assembling food to keep hair from contacting exposed food, clean equipment, utensils, and linens. On 8/12/24 at 0850 hours, the DSS was observed working on the breakfast tray line wearing a face mask with facial hair and no beard restraint. On 8/12/24 at 0910 hours, an interview was conducted with the DSS. The DSS stated he should wear a beard net. a. On 8/12/24 at 0930 hours, the Maintenance Director was observed with uncovered facial hair as he checked the ice machine. On 8/12/24 at 1535 hours, an interview was conducted with the DSS . The DSS verified the Maintenance Director should wear a facial hair covering when inside the kitchen. b. On 8/13/24 at 1038 hours, [NAME] 2 was observed with exposed arm hair while he prepared sandwiches. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/13/24 at 1039 hours, an interview was conducted with the DSS. The DSS stated [NAME] 2 should wear covering on his arms. c. On 8/13/24 at 1110 hours, the ice machine vendor was observed in the kitchen with facial hair not covered. The DSS asked the ice machine vendor to don a beard net. 4. According to the USDA Food Code 2022 Section 4-501.19 Manual Warewashing Equipment, Wash Solution Temperature. The temperature of the wash solution in manual shall be maintained at not less than 43 degrees Celsius (110 degrees F) or the temperature specified on the cleaning agent manufacturer's label instructions. On 8/13/24 at 1057 hours, an observation of the manual ware washing sink and concurrent interview was conducted with DA 1 using the DSS as a translator. According to the surveyor's thermometer, the wash water temperature was 107.4 degrees F. When asked how DA 1 measured the wash water temperature, DA 1 stated he did not have a thermometer. DA 1 was asked how he checked the water temperature he stated he felt the wash water with his hands. DA 1 added he changed the wash water as soon as he was finished washing the dishes. 5. Review of the facility's P&P titled HPSI Policy and Procedure Manual Guidelines for the Food and Nutrition Services Department revised 2/4/20, showed in Section F Safety and Sanitation Ware Washing, Two compartment Sink Method: 1. Fill sink #1 to the marked water line with clean hot water then add detergent according to the chemical vendor instructions. 2. Fill sink #2 to the marked line with clean hot water. 3. Wash service ware thoroughly in the hot detergent, rinse in a clear water sink#2. 4. Drain sink #2, refill with appropriate amounts of sanitizing solution and water. 5. Use the provided test strips to test the concentration of the sanitizing solution and record on the sanitizing sink log. If the solution is incorrect, notify the supervisor and DO NOT use until the correct concentration is available and verified. 6. Submerge the clean dishes in the sanitizing solution according to chemical vendor's time requirements. 7. Place sanitized dishes on the drain board to air dry. On 8/13/24 at 1046 hours, an observation of manual warewashing and a concurrent interview was conducted with DA 1 using the DSS as translator. The manual ware washing sink was comprised of two sinks; the first sink contained soapy wash water and the second sink contained sanitizer. DA 1 was asked to demonstrate the manual ware washing procedure using the two-sink method. DA 1 stated he washed the dishes in the wash water. DA 1 stated he used the sprayer to rinse the dishes. DA 1 stated he used the second sink to sanitize the dishes. The DSS commented that the county had approved using the sprayer to rinse the dishes. The surveyor asked for confirmation the county had approved using the sprayer to rinse the dishes. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/19/24 at 0830 hours, an interview was conducted with the DSS. The DSS was asked about the county approving the sprayer used to rinse dishes in the manual ware washing sink. The DSS stated the county did not give anything in writing which approved using the sprayer to rinse the dishes only that the county did not mention it was a concern. 6. According to the USDA Food Code 2022 Section 6-501.113 Storing Maintenance Tools. Maintenance tools such as brooms, mops, vacuum cleaners, and similar items shall be: (A) Stored so they do not contaminate food, equipment, utensils, linens and single-service and single-use articles; and (B) Stored in an orderly manner that facilitates cleaning the area used for storing the maintenance tools. Review of the facility's P&P titled Cleaning and Disinfection of Environmental Surfaces revised 8/2019 showed mop heads and cleaning cloths will be decontaminated regularly. During the initial tour of kitchen on 8/12/24 at 0743 hours, the mop room was observed with one mop in a bucket with blackish water and another mop bucket with two dirty mop heads stored inside. On 8/12/24 at 0850 hours, an interview was conducted with the DSS. The DSS acknowledged the dirty mops and mop buckets and stated the mop buckets should have been emptied immediately and the mop heads taken to the laundry. 7. According to the USDA Food Code 2022 Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils (C) Nonfood contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris. a. During the initial kitchen tour on 8/12/24 0743 hours, there were five fans observed in the kitchen with black residue: - one boxed fan on a food preparation counter - one boxed fan on the floor by the food preparation sink - one wall fan by the ice machine - two fans in the dishwashing area On 8/12/24 at 0910 hours, an interview was conducted with the DSS. The DSS agreed the fans had black residue and stated it was maintenance responsibility to clean the fans in the kitchen. On 8/12/24 at 0930 hours, an interview with the Maintenance Director. The Maintenance Director stated the fans in the kitchen were cleaned every two months but could not verify the last time when the fans were cleaned. The Maintenance Director stated they did not keep a maintenance log for cleaning the fans in the kitchen. The Maintenance Director further stated the residue on the fans in the kitchen did not come off and agreed the fans should be replaced. b. On 8/14/24 at 1000 hours, an observation of the dishwashing and concurrent interview was conducted with the DSS. Clean plates were observed stacked on a three-tier cart. The corners of each tier of the cart had an orange-brownish residue which resembled rust. The DSS confirmed the cart had an orange-brown residue and agreed the cart should be replaced.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 39856 Based on observation, interview and facility P&P review, the facility failed to ensure the facility staff and resident visitors were educated on safe food handling practices when food from the outside was brought to the facility for resident consumption. This failure had the potential for unsafe food handling which could lead to food borne illness in the xx residents who resided in the facility. Findings: Review of the facility's P&P titled Foods Brought by Family/Visitors revised 3/2022 showed in part, safe food handling practices are explained to family/visitors in a language and format they understand. Review of the facility in-service lesson plan and attendance record titled Food Brought by Family/Visitors dated 6/17/24, showed the in-service was conducted by the IP. The in-service included policy interpretation and implementation which reviewed the policy specifics however safe food handling was not included. On 8/12/24 at 1622 hours, an observation of the refrigerator used to store the resident food brought to the facility from the outside and concurrent interview was conducted with LVN 5. When asked how the visitors were educated on safe food handling practices, LVN 5 stated she was not sure how the visitors were educated on safe food handling practices. When asked if she had received education on safe food handling, LVN 5 stated she could not remember. On 8/13/24 at 0753 hours, an interview was conducted with the IP. The IP provided an in-service lesson plan dated 6/17/24, titled Food Brought by Family/Visitors. When asked if the in-service lesson plan included information on safe food handling, the IP confirmed the in-service lesson plan did not include information on safe food handling. On 8/13/24 at 0907 hours, an additional interview was conducted with the IP. The IP was asked how the visitors were educated on safe food handling practices. The IP stated safe food handling was common sense and that no handout was provided for visitors regarding safe food handling practices. The IP added that visitors were educated on the facility's policy regarding food brought from the outside but no specific safe food handling information was provided to the visitors.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on interview, medical record review, and facility document review, the facility failed to provide the necessary care and services for one of three residents (Resident 159) reviewed for hospice services. * The facility failed to ensure Resident 159's hospice record was included in the resident's medical record. Resident 159's hospice nurse and aide visit progress notes were not found in Resident 159's the medical record. This failure posed the risk for delay in communication between the hospice provider and facility which may affect Resident 159's care. Findings: Review of the facility's contract with Hospice Provider A dated 5/17/24, showed the following: - The hospice agency and facility shall develop a process to exchange information between the interdisciplinary group and facility staff regarding development and updating of the plan of care and evaluation of care outcomes to ensure that each hospice patient receives necessary and appropriate care and services. - At each visit with a hospice patient, the hospice RN shall review and document adherence to the plan of care and the overall quality of care. - The facility shall prepare and maintain complete and detailed records concerning each hospice patient receiving facility services under this agreement in accordance with prudent record-keeping procedures and as required by applicable federal and state laws . Each clinical record shall completely, promptly, and accurately document all services provided to, and events concerning, each hospice patient, including evaluations, treatments, progress notes, authorizations to admission to hospice and/or facility . Each record shall document that the specified services are furnished accordance with this agreement and shall be readily accessible and systematically organized to facilitate retrieval by either party. Medical record review for Resident 159 was initiated on 8/12/24. Resident 159 was admitted to the facility on [DATE]. Review of Resident 159's Order Summary Report for August 2024 showed the following physician's orders: - dated 8/2/24, for hospice services with Hospice Provider A, - dated 8/2/24, for HA visits two times a week, MSW visit one time a month and as needed, SN visits three times a week and three visits as needed, and (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 8/12/24, for HA visits three times a week, SN visits two times a week and as needed visits. Review of Resident 159's hospice visitation calendar for August 2024 showed the following: - The SN visits were scheduled on 8/2, 8/5, 8/7, 8/9, 8/10, 8/11, 8/12, and 8/13/24. - The HA vists were scheduled on 8/5, 8/7, 8/9, 8/12, 8/14, and 8/16/24. Review of Resident 159's hospice records failed to show any nursing progress notes for the above listed dates and failed to show any HA documentations for the above listed dates. On 8/14/24 at 1405 hours, an interview was conducted with RN 1. RN 1 was asked to show Resident 159's hospice binder. RN 1 stated the hospice residents no longer had a hospice binder, and all hospice record were on the electronic health records in the resident's medical records. On 8/15/24 at 1246 hours, a follow-up interview and concurrent medical record review was conducted with RN 1. RN 1 stated Resident 159 was being seen by a hospice RN everyday and the hospice RN documented her visits in her own hospice binder. RN 1 stated the hospice RN sent all progress notes to the medical records and medical records was responsible for uploading the hospice documents into the resident's medical record. RN 1 was asked how the care between the facility and hospice agency were communicated for each visit, RN 1 stated she viewed the hospice nurse's progress notes. RN 1 was asked to show the hospice RNs' progress notes for the past visits where Resident 159 was seen. RN 1 verified the progress notes of the past visits of the hospice nurse or aide visits were not uploaded in Resident 159's medical records. On 8/15/24 at 1435 hours, an interview and concurrent record review for Resident 159 was conducted with the DON. The DON stated he was the facility's hospice coordinator. The DON stated he expected all the hospice documents to be uploaded into the resident's medical records within 72 hours of the hospice nurse visits and including the hospice aide visits. The DON verified the above findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to maintain the infection prevention control program and practices designed to provide a safe and sanitary environment to help prevent the transmission of communicable diseases and infections. * The facility failed to maintain an accurate infection control surveillance program for July 2024. The facility conducted surveillance only on the residents who exhibited signs and symptoms of an infection and were prescribed antimicrobial medications. The facility failed to ensure the residents exhibited signs and symptoms of an infection but were not prescribed antimicrobial medications (including residents diagnosed with Candida Auris infection) were included in the facility's infection control surveillance log, and in the monthly infection surveillance report. In addition, the facility failed to correctly classify CAIs and HAIs, and failed to correctly identify the HAIs that met or did not meet the Revised McGeers Criteria. These failures posed the risk for not identifying resident infections and thereby, preventing the implementation of interventions to control the potential transmission of communicable diseases to other residents in the facility. * The facility failed to ensure the clean linen cart did not contain a broom handle, and not dusty. This had the potential for cross contamination. * The facility failed to ensure LVN 9 sanitized the blood pressure (BP) cuff (device used to read the pressure of the blood in the circulatory system) and stethoscope (a medical instrument used to detect sounds produced in the body) after use for Resident 32. * The facility failed to ensure LVN 10 performed hand hygiene between medication routes during medication observation for Resident 4. * The facility failed to ensure the Wound Consultant performed hand hygiene in between glove uses. * The facility failed to ensure CNA 5 followed droplet precautions when entering the room of a resident on transmission-based precautions. This failure posed the risk of infection and transmission of disease-causing microorganism. * The facility failed to ensure hand hygiene practices was followed when RNA 1 failed to perform hand hygiene when assisting Residents 65 and 57 with eating in the dining room. These failures had the potential to spread infection in the facility. Findings: 1. According to the Epidemiology of Community-Acquired and Nosocomial Infections by [NAME] and [NAME], published in the International Journal of Medical Microbiology, in 2013, showed any infection occurring within the first 48 hours of hospitalization is considered community-acquired while any infection occurring after 48 hours is considered nosocomial. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's P&P titled Infection Control Policy revised date 9/5/17, showed infections are significant source of sickness and death for nursing home residents and account for up to half of all nursing home resident transfers to hospitals. When a nursing home resident is hospitalized with a primary diagnosis of infection, the death rate can reach as high as 40 percent. The purpose of the infection control program is to investigate, control and prevent infection in the facility, and to maintain a record of incidents and corrective actions taken related to infections by reporting incidents through the proper facility chain of command. On 8/16/24 at 1103 hours, a concurrent interview, medical record review, and facility document review was conducted with the IP. The IP was asked to show the facility's infection control surveillance program for July 2024. Review of the Infection Prevention and Control Surveillance Log for July 2024 showed the following: a. The infection control surveillance was only conducted for the residents prescribed with antibiotics. There was no documented evidence of surveillance for the residents who exhibited signs and symptoms of infection but were not prescribed antimicrobial medications, such as the residents diagnosed with Candida Auris infection were included in the surveillance log. Review of the facility's document showed there were six residents with Candida Auris in the facility on enhanced barrier precautions. These six residents were not included in the surveillance log. When the IP was asked to describe the facility's infection surveillance program, the IP stated he would initially do an order listing report from the electronic health record and select the residents on antibiotic and run the report. The IP stated he would then manually enter the information of the residents prescribed with antibiotics to the surveillance log. The IP stated he conducted surveillance only on the residents with infections who were prescribed antimicrobial medications. When asked if the residents who exhibited signs and symptoms of infection but were not prescribed antimicrobial medications were included in the surveillance, the IP stated he did not include the residents who exhibited signs and symptoms of infection but were not prescribed antimicrobial medications such as those residents with Candida Auris. b. The infection control surveillance did not show an accurate classification between CAI and HAI. For example, the documentation showed Resident 38 was admitted on [DATE], and the onset of the signs of symptoms of GI (gastrointestinal) infection were on 7/19/24. This was classified as HAI. When asked about CAIs and HAIs, the IP stated CAIs or community-acquired infections were the infection the residents had before admission and would usually continue the antibiotic treatment at the facility; while HAIs or hospital-acquired infections were the infections that the residents developed in 72 hours after admission. The IP stated when he entered the resident information on the surveillance log, it automatically identified the infection as HAI or CAI based on the onset dated entered. When asked for the documentation of Resident 38's medical record to show why the infection was classified as HAI, the IP stated the resident was admitted with the antibiotic, and the infection should have been classified as HAI. c. The infection control surveillance did not show the HAIs were accurately identified as meeting or not meeting the revised McGeer Criteria. For example: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Resident 1 had the left second toe infection and was prescribed with antibiotic. This was identified as HAI, meeting the McGeer Criteria. When asked to show documentation how he identified the infection as HAI meeting McGeer Criteria, the IP showed the Daily Overview document from the electronic health record showing Resident 1 had an edema, warmth and skin discoloration (yellow/ brown toenail). This did not meet the revised McGeer Criteria for skin. - Resident 66 had the UTI and was prescribed with antibiotic. This was identified as HAI, meeting McGeer Criteria. When asked to show documentation how he identified the infection as HAI meeting McGeer Criteria, there was no documentation to show the infection met the revised McGeer Criteria for UTI. - Resident 76 had the UTI and was prescribed with antibiotic. This was identified as HAI meeting McGeer Criteria. When asked to show documentation how he identified the infection as HAI meeting McGeer Criteria, the IP showed an eInteract Change of Condition dated 7/14/24, showed Resident 76 had a gross hematuria; and the IP showed a laboratory test for UA C/S dated 7/14/24, showing the resident's urine had less than 10, 000 colonies/ml gram negative bacilli. This did not meet the revised McGeer Criteria for UTI. - Resident 159 had the respiratory infection and was prescribed with antibiotic. This was identified as HAI meeting McGeer Criteria. When asked to show documentation how he identified the infection as HAI meeting McGeer Criteria, there was no documentation to show the infection met the revised McGeer Criteria for respiratory. The IP verified the above findings. The IP stated the resident's information he entered on the surveillance log would automatically populate in the Monthly Infection Prevention and Control Report which would be presented to the Infection Control Committee meeting. 2. On 8/14/24 at 0951 hours, an inspection of the laundry area and concurrent interview and facility document review was conducted with the Housekeeping and Laundry Supervisor. A clean linen cart with clean gowns was observed with a broom handle touching the gowns, and a bin collecting dust and food debris was observed under the wire shelf. The Housekeeping and Laundry Supervisor verified the above findings. 47474 3. Review of the facility's P&P titled Handwashing/Hand Hygiene revised on 10/2023 showed the facility considers hand hygiene and primary means to prevent the spread of healthcare-associated infections. All personnel are expected to adhere to hand hygiene policies and practices to help prevent and spread of infections to other personnel, residents, and visitors. In addition, the P&P showed the use of gloves does not replace hand washing hand hygiene. The P&P further showed hand hygiene is indicated for the following: a. Immediately before touching a resident. d. After touching a resident. e. After touching the resident's environment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medical record review for Resident 32 was initiated on 8/12/24. Resident 32 was admitted to the facility on [DATE] and readmitted back to the facility on [DATE]. Review of Resident 32's quarterly MDS dated [DATE], showed Resident 32 had a BIMS score of 00 which meant the resident's cognition was severely impaired. On 8/14/24 at 0803 hours, an observation of LVN 9 was conducted during the medication observation for Resident 32. LVN 9 was observed using the BP cuff and stethoscope to assess Resident 32's BP levels. Further observation showed LVN 9 placed the used BP cuff and stethoscope on top of the cleaned medication cart next to Resident 32's medications. On 8/14/24 at 0933 hours, an interview with LVN 9 was conducted. LVN 9 verified the BP cuff and stethoscope were not sanitized after use. LVN 9 stated he should have sanitized the BP cuff and stethoscope after use to prevent the spread of infection. 4. Medical record review for Resident 4 was initiated on 8/12/24. Resident 4 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 4's quarterly MDS dated [DATE], showed Resident 4 had a BIMS score of 8 which meant the resident's cognition was moderately impaired. On 8/14/24 at 0945 hours, an observation of LVN 10 was conducted during the medication observation for Resident 4. LVN 10 did not perform hand hygiene when administering Resident 4's medications through different routes including oral, topical (applied on the skin), and subcutaneous (puncture beneath the skin). On 8/14/24 at 1032 hours, an interview with LVN 10 was conducted. LVN 10 acknowledged hand hygiene was not performed between the different medication routes. LVN 10 stated he should have performed hand hygiene between medication routes to avoid contamination and decrease the risk of spreading infection. On 8/19/24 at 1350 hours, an interview with the Administrator and DON was conducted. The Administrator and DON acknowledged above findings. 48882 5. Medical record review for Resident 13 was initiated on 8/12/24. Resident 13 was admitted to the facility on [DATE]. Review of Resident 13's MDS dated [DATE], showed Resident 13 had severe cognitive impairment. Review of Resident 13's Order Summary Report showed the following physician's orders: - dated 6/10/24, for the right heel pressure injury, to cleanse with normal saline (NS), pat dry, apply Santyl (topical medicine that removes dead tissue from wounds to promote wound healing) and mupirocin (topical medicine used to treat secondarily infected traumatic skin lesions due to specific bacteria) to the wound bed and cover with foam dressing one time a day, and as needed if dislodged or soiled; and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- dated 8/13/24, to apply triamcinolone (topical corticosteroid) for skin rash on the neck extending to the right and left shoulders one time a day for 21 days. On 8/15/24 at 0818 hours, an observation of the Wound Consultant and LVN 3 was conducted during the wound treatment observation for Resident 13. The Wound Consultant was observed removing her gloves after a bedside debridement (a medical procedure that removes dead, damaged, or infected tissue from a wound to improve the healing process) of Resident 13's right heel. The Wound Consultant was then observed donning multiple layers of gloves without performing hand hygiene. The Wound Consultant was observed applying Santyl ointment to Resident 13's right heel and covering with a foam dressing. The Wound Consultant then removed and discarded the top layer of her gloves, and with the pair of gloves underneath proceeded to remove the dressing on Resident 13's sacral area. The Wound Consultant was observed discarding the dressing and her gloves and with another pair of gloves underneath, she proceeded to clean Resident 13's sacral area with wound cleanser and gauze. The Wound Consultant was not observed performing hand hygiene in between glove use. When the Wound Consultant completed her evaluation, LVN 3 was observed with gloves on and applying triamcinolone cream on Resident 13's chest. LVN 3 was then observed removing her gloves and donned a new pair of gloves to apply bilateral sleeves on Resident 13's forearms. LVN 3 was not observed performing hand hygiene in between glove use. On 8/15/24 at 0837 hours, an interview was conducted with LVN 3. LVN 3 verified the above findings. LVN 3 stated gloves should be worn as one pair at a time, and hand hygiene should be performed in between each glove use. On 8/19/24 at 0856 hours, a phone interview was conducted with the Wound Consultant. The Wound Consultant verified she donned multiple pairs of gloves at once during the wound evaluation for Resident 13. The Wound Consultant stated gloves were single use and should be removed and hand hygiene performed in between each glove use. On 8/19/24 at 1515 hours, an interview was conducted with the DON. The DON stated when using gloves to provide care, there should be no double gloving. The DON stated the staff should use one pair of gloves per use and gloves should be discarded after each use and hand hygiene should be performed in between glove use, to prevent the transmission of infections. The DON was informed and acknowledged the above findings. 6. Review of the facility's P&P titled Coronavirus Disease (COVID -19) -Identification and Management of Ill Residents revised 5/23 showed staff who enter the room of a resident with suspected or confirmed SARS-Co V-2 infection will adhere to standard precautions and use a NIOSH (National Institute for Occupational Safety and Health)-approved particulate respirator with N95 filters of higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). On 8/12/24 at 1241 hours, an observation was conducted of CNA 5. CNA 5 was observed wearing a face mask, gloves, and gown; and entering Resident 826's room with a lunch tray. A purple sign was observed posted outside of Resident 826's room alerting anyone entering the room to clean their hands on room entry, don an N95 mask and face shield or goggles, don gloves, prior to entering the resident's room. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/12/24 at 1244 hours, an interview was conducted with CNA 5. CNA 5 stated Resident 826's room was on isolation for COVID. CNA 5 stated prior to entering the resident's room, she should don a gown, gloves, face shield and N95 mask. CNA 5 verified she did not don an N95 mask or face shield when she entered Resident 826's room to drop off her lunch meal tray. Medical record review for Resident 826 was initiated on 8/12/24. Resident 826 was admitted to the facility on [DATE] with a diagnosis of COVID-19. Review of Resident 826's Order Summary Report showed a physician's order dated 8/7/24 for Transmission Based Precautions: Contact, Droplet, and Respiratory Isolation for Corona Virus for 10 days, every shift. On 8/14/24 at 1424 hours, an interview was conducted with the IP. The IP stated staff should be fully gowned with an N95 mask, gloves, and face shield when entering a COVID isolation room. On 8/19/24 at 1515 hours, an interview was conducted with the DON. The DON stated anyone entering a COVID isolation room should don gloves, gowns, face shield, and N95 mask. The DON stated the potential risk of noncompliance, may be transmission of communicable diseases to other residents and individuals in the facility. The DON was informed and acknowledged the above findings. 48853 7. On 8/12/24 at 1245 hours, during the dining room observation, RNA 1 was observed by two surveyors feeding Resident 65 then RNA 1 assisted Resident 57 to hold the drinking cup and then assisted Resident 65 with eating again without practicing hand hygiene in between the two residents. * Medical records review for Resident 65 was initiated on 8/12/24. Resident 65 was admitted on [DATE]. Review of Resident 65's Order Summary Report dated 8/15/24, showed a physician's order dated 11/9/23, for feeding assistance for breakfast, lunch, and dinner. Review of Resident 65's Order Summary Report dated 8/19/24, showed a physician's order dated 1/27/24, for 1:1 (one resident : one nurse/staff) feeding assistance. * Medical records review for Resident 57 was initiated on 8/12/24. Resident 57 was admitted on [DATE] and readmitted on [DATE]. On 8/19/24 at 0832 hours, an interview was conducted with the IP. The IP stated the staff were expected to assist the residents in the dining room one at a time. The IP further stated if the staff was currently assisting or feeding one resident and needed to assist another resident, the staff should wash hands or call someone else to assist the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056110	A. Building B. Wing	08/19/2024

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 39453 Based on interview, facility document review, and facility P&P review the facility failed to monitor and address the use of antibiotics when the resident's condition did not meet McGeer's criteria (a set of specific definitions to identify true infections in long term nursing facilities) for one of 35 final sampled residents (Resident 136) and two nonsampled residents (Residents 12 and 142). This failure had the potential for antibiotics to be used when it was not indicated and the development of antibiotic-resistant bacteria. Findings: Review of the facility's P&P titled Antibiotic Stewardship-Order for Antibiotics dated December 2016 showed appropriate use of antibiotic included criteria met for clinical definition of active infection or suspected sepsis and pathogen susceptibility, based on culture and sensitivity, to antimicrobial (or therapy begun while culture is pending). Review of the facility's P&P titled Antibiotic Stewardship-Review and Surveillance of Antibiotic Use and Outcome revised December 2016 showed the IP or designee will review antibiotic utilization as a part of the antibiotic stewardship program and identify specific situation that are not consistent with the appropriate use of antibiotic. The P&P further showed at the conclusion of the review, the provider to be notified of the review findings. Review of the facility's document titled Infection Prevention and Control Surveillance Log dated July 2023 showed Residents 12, 136, and 142 were prescribed antibiotic for UTI but did not meet the McGeer Criteria. Review of the Surveillance Data Collection and Infection Control Form dated 7/2/23, showed Resident 136's infection did not meet McGeer Criteria. Review of the Surveillance Data Collection and Infection Control Form dated 7/6/23, showed Resident 142's infection did not meet the McGeer Criteria. Review of the Surveillance Data Collection and Infection Control Form (undated) showed Resident 12's infection did not meet the McGeer Criteria. Review of the medical records for Residents 12, 136, and 142 failed to show documented evidence if the physician was notified of the infections that did not meet the McGeer criteria. On 9/11/23 at 0917 hours, an interview and concurrent facility document review was conducted with the IP. The IP verified the above findings. The IP was asked about the facility's antibiotic stewardship program. The IP stated the facility used the McGeer criteria. The IP stated if a resident did not meet the criteria for an infection using McGeer criteria, the physician would be notified. When the IP was asked to show the documentation if the physicians had been notified when the infection criteria were not met for the above residents, the IP reviewed the medical records for the above residents and stated he was unable to provide the documentation.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 48853 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the facility's ice machines were maintained in proper working condition when: - One of two ice machine was not clean. - Two of two ice machines were not sanitized according to the manufacturer's instruction guide. - Two of two ice machines did not have backflow prevention. These failures posed the risk of equipment to not function properly, which could negatively impact the residents' well-being. Findings: 1. According to the USDA Food Code 2022, Section 4-601.11 Food Contact Surfaces, Nonfood Contact Surfaces, and Utensils (A) Equipment, food contact surfaces and utensils shall be clean to sight and touch. On 8/12/24 at 0930 hours, an observation of the ice machine was conducted with the Maintenance Director. The chute of Ice Machine 1 (the interior area where ice is dropped into the ice storage bin) had a black residue. The Maintenance Director confirmed the finding and agreed there should not be any residue inside the ice machine. 2. Review of the facility's P&P titled Sanitation revised on November 2022 showed the ice machine and ice storage are drained, cleaned, and sanitized per manufacturer's instructions. Review of the ice machine Cleaning/Sanitizing Procedure located on the inside cover of Ice Machine 1 showed Step 15, when water through has refilled (approximately one minute), and the display indicates; add the proper amount of ice machine sanitizer to the water through by pouring between the water curtain and evaporator. Review of Ice Machine 2 Cleaning Procedure showed Step 13: set the switch to wash position to start automatic cleaning. Water is supplying automatically. Add 30 ml of sanitizer to the water container and Step 14: wait until the sanitization cycle is complete (approximately 21 minutes) then place the switch in the OFF. Turn the switch back in wash and repeat the sanitizer cycle when sanitizer residue still in the water container. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/13/24 at 1110 hours, concurrent interview was conducted with the ice machine vendor. The ice machine vendor stated he was responsible for cleaning the facility's ice machine every other month. The ice machine vendor stated he took parts of the ice machine out then cleaned with the cleaner mixed with one gallon water and 16 oz. chemical and runs through clean cycle for 30-40 minutes. He sprayed the surface of the parts taken out of the machine with sanitizer using one gallon water with 2 oz of sanitizer. He then cleaned the ice bin with the cleaner, rinsed, and sanitized. The ice machine vendor stated he followed the same procedure in cleaning Ice Machine 2. The ice machine vendor confirmed he did not do Step 15 as stated in the Cleaning/Sanitizing Procedure of the manufacturer's guide for Ice Machine 1 and Cleaning Procedure, Steps 13 and 14 for Ice Machine 2. 3. According to the USDA Food Code 2022 5-402.11 Backflow Prevention, (A) a direct connection may not exist between the SEWAGE system and a drain originating from equipment in which food, portable equipment, or utensils are placed. On 8/12/24 at 0930 hours, an observation of Ice Machines 1 and 2 and concurrent interview was conducted with the Maintenance Director. The Maintenance Director was asked to show the air gap of the ice machine. The Maintenance Director showed the drainpipes of the ice machines were connected to the main sewage drain for both ice machines. On 8/12/24 at 1642 hours, an interview was conducted with the Administrator. The Administrator stated the ice machines did not have the air gap for the back flow; however, he would make sure it would be fixed.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683 Based on observation, interview and the facility's P&P review, the facility failed to ensure the call light system was functioning for one of 172 residents in the facility (Resident 128). This failure had the potential for a delay of the resident alerting the staff for assistance. Findings: Medical record review for Resident 128 was initiated on 8/12/24. Resident 128 was admitted to the facility on [DATE]. On 8/12/24 at 0838 hours, an observation and concurrent interview was conducted with Resident 128. Resident 128 was in the bed and stated they pressed their call light button for staff assistance. The call light indicator did not show above the resident's doorway. Resident 128 pushed the call light button again, and the indicator light did not illuminate above the resident's doorway. The writer left the room to observe the call light panel located on the desk at the nurses' station, and did not see the resident's room illuminated, and there were no audible call-light indicator alerts. On 8/12/24 at 0844 hours, an observation and concurrent interview were conducted with CNA 11. CNA 11 was asked to push Resident 128's call light button, CNA 11 pushed the button and the indicator failed to illuminate. CNA 11 then reached behind the resident's head-of-bed and stated the call light cord was not all the way pushed or all the way in. Then, the CNA pushed the call light button, and the indicator was illuminated. On 8/13/24 at 1422 hours, an observation and concurrent interview were conducted with the Maintenance Director at Resident 128's bedside, the resident was not currently in the room. The Maintenance Director stated if the call light cord was pulled out from the wall, it would illuminate on the wall in the room, above the doorway, and at the nurses' station panel along with an audible alert. The Maintenance Director stated if the cord was only partially pulled out, it would not make any indicator alerts.