STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056111	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Griffith Park Healthcare Center	201 Allen Ave. Glendale, CA 91201

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46779 Based on observation, interview, and record review, the facility failed to: 1. Ensure the residents' Physican Orders for Life-Sustaining Treatment (POLST, a written order from a provider that outlined a patient ' s preference for medical treatment) were in the resident's clinical record for three of seven sampled residents (Resident 66, 69, and 77). 2. Ensure the resident's POLST and Advance Directive (AD, written statement of a person's wishes regarding medical treatment should the person be unable to communicate them to a doctor) acknowledgement forms were in the resident ' s clinical record for one of seven sampled residents (Resident 14). These deficient practices had the potential to cause conflict with the residents' wishes regarding their healthcare decisions. Findings: 1a. During a review of Resident 66's Admission Record, indicated the facility admitted Resident 66 on 7/1/2022 with diagnoses that included anxiety disorder (a mental health condition that involves persistent and excessive worry that interferes with daily activities) and dementia (a chronic condition that causes a decline in mental abilities, such as thinking, remembering, and reasoning, that interferes with daily life). During a review of Resident 66's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 10/10/2024, indicated Resident 76 had severely impaired cognitive skills for daily decision making. During a concurrent interview and record review on 10/21/2024 at 4:30 PM, with Registered Nurse (RN) 2, Resident 66's paper chart was reviewed. RN 2 stated there was no POLST in Resident 66's paper chart. During a concurrent observation and interview on 10/21/2024 at 4:31 PM, RN 2 was observed taking out Resident 66's hospice chart, which was placed underneath the desk in the nurses' station. RN 2 stated they kept a copy of Resident 66's POLST in the hospice chart. RN 2 stated it was important to keep the POLST in Resident 66's facility chart so if there was an emergency, the POLST could be easily accessible by facility staff when placed in Resident 66's paper chart. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1b. During a review of Resident 69's Admission Record indicated the facility originally admitted Resident 69 on 4/10/2023 and readmitted on [DATE] with diagnoses that included diabetes (a group of disease that result in too much sugar in the blood) and hyperlipidemia (a condition in which there are high levels of fat in the blood). During a review of Resident 69's MDS, dated [DATE], indicated Resident 69 had moderately impaired memory and cognition (ability to think and reason). During a concurrent interview and record review on 10/21/2024 at 4:32 PM, with RN 2, Resident 69's paper chart was reviewed. RN 2 stated there was no POLST in Resident 69's paper chart. During a concurrent observation and interview on 10/21/2024 at 4:33 PM, RN 2 was observed obtaining a binder, labeled with a physician's name, from underneath the desk in the nurses' station, which had Resident 69's POLST. RN 2 stated facility staff collected and kept residents' documents that required a physician's signature in the binder, so the physician could sign those when the physician came to facility. During a concurrent interview and record review on 10/21/2024 at 4:34 PM, Resident 69's POLST, dated 8/2/2024, was reviewed. RN 2 stated Resident 69 had completed and signed the POLST on 8/2/2024, but the physician had not signed the order since Resident 69 had signed the POLST on 8/2/24. RN 2 stated the physician should have signed the order earlier. RN 2 stated Resident 69's POLST should be kept in Resident's 69's paper chart instead of the binder, which was located underneath the desk in the nurses' station. RN 2 stated the POLST was an indication of the code status of residents an their wishes during emergent medical treatment. 1c. During a review of Resident 77's Admission Record indicated the facility admitted Resident 77 on 8/1/2024 with diagnoses that included diabetes and hyperlipidemia. During a review of Resident 77's MDS, dated [DATE], indicated Resident 77 had moderately impaired memory and cognition. During a concurrent interview and record review on 10/21/2024 at 4:35 PM, with RN 2, Resident 77's paper chart was reviewed. RN 2 stated Resident 77's POLST was not in Resident 77's physical chart and could did not know what Resident 77's wishes were during emergency medical treatment. During an interview on 10/21/2024 at 4:36 PM, with the Director of Nursing (DON), the DON stated POLST should be signed by the residents and the physician and kept in resident's paper chart so that facility staff would know the code status and residents' wishes regarding treatment during a medical emergency. During a review of the facility's policy and procedure (P&P) titled, During a review of the facility's policy and procedure (P&P) titled, Physician Orders for Life Sustaining Treatment (POLST), dated 9/2018, indicated the purpose of POLST was to provide resident and responsible party the option to honor their desire/choice or preference for life-sustaining treatment. The P&P indicated POLST form is legally recognized as a physician order and must be signed a physician. The P&P indicated POLST form would be filed in the Advanced Directive or the legal section of the medical record. 50203 (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 14's Admission Record (Face sheet), the facility admitted Resident 14 on 1/13/2020 and readmitted him on 9/7/2023 with diagnoses of bipolar (a mental illness that causes extreme mood swings that range from lows of depression to elevated periods of emotional highs) schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) and nicotine (a highly addictive substance found in cigarettes, cigars, and e-cigarettes) dependence. During a review of Resident 14's Letter of Conservatorship (when a judge appointed another person to act and make decisions for a person who needs help), dated 2/22/2021, this document indicated that Resident 14 was still gravely disabled and was reappointed a conservator. During a review of Resident 14's History and Physical (H&P, a comprehensive physician's note regarding the assessment of the resident's health status), dated 6/29/2024, indicated Resident 14 did not have the capacity to understand and make decisions. During a review of Resident 14's Minimal Data Set (MDS, a federally mandated resident assessment tool), dated 8/22/2024, indicated the resident was cognitively (a person's ability to think, reason, and judge) intact. During a concurrent interview and record review on 10/23/2024 at 12:22PM with Registered Nurse (RN) 1, the POLST and AD acknowledgement form was not present in Resident 14's clinical records. RN 1 stated, there was no documented evidence that a POLST or AD Acknowledgement form was completed and was offered to Resident 14's. RN 1 stated, it was important to have resident's POLST in the clinical records and readily accessible to know what the resident's wishes were in case of an emergency. During a review of the facility's policies and procedures (P&P) titled Physican Orders for Life Sustaining Treatment (POLST), dated 9/2018, indicated the facility will make a copy of the completed POLST form and file the POLST in the resident ' s clinical records. During a review of the facility's P&P titled, Advance Directives, revised 9/2022, indicated written information about the right to formulate an advanced directive was provided in a manner that was easily understood by the resident or representative. The P&P indicated the facility staff will offer assistance in establishing an advance directive and the nursing staff will document in the medical records the offer to assist and the resident's decision to accept or decline assistance.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan to address Resident 45's refusal to treat the long nails with [NAME] infection and for podiatric (a physician specialized in foot treatment) treatment on 10/7/2024. This deficient practice had a potential result in Resident 45's inadequate and incomplete provision of care and result in worsened foot infection. Cross Reference to F687. Findings: During a review of Resident 45's Admission Record, indicated Resident 45 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included paraplegia (chronic condition that refers to the loss of muscle function in the lower half of the body, including the legs and sometimes the abdomen), primary osteoarthritis (arthritis that occurs when flexible tissue at the ends of bones wears down). During a review of Resident 45's Order Summary Report, indicated on 3/18/2024 Resident 45 had a physician order for podiatry care every 60-90 days as needed for mycotic (a fungal infection that affects the fingernails or toenails), hypertrophic (the abnormal enlargement) toenails and/or foot problems. During a review of Resident 45's History and Physical (H&P), dated 7/27/2024, indicated Resident 45 had the capacity to understand and make decisions. During a review of Resident 45's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/25/2024, indicated Resident 45 ' s cognition (ability to think, remember, and reason with no difficulty) was intact, and needed moderate assistance for personal hygiene. During a review of Resident 45's Patient Care Plan: ADL (Activities of Daily Living, the basic tasks people need to do to care for themselves, such as eating, dressing, and using the toilet) Function, dated 7/25/2024, indicated Resident 45 had ADL deficit related to extensive assistance in personal hygiene, the goal was that the resident would be able to groom daily, and the interventions included to assist with ADL as needed. During a review of Resident 45's Podiatric Evaluation and Treatment, dated 10/7/2024, indicated no podiatric evaluation and treatment completed due to Resident 45's refusal. During a review of Resident 45's Plan of Care Note, dated 10/11/2024, indicated Resident 45 refused to be seen by Podiatry on 10/7/2024. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 10/23/2024 at 10:24 AM in Resident 45's room, Resident 45's left and right big toe' nails that were approximately one-inch-long toenail. Resident 45 stated, his toenails were too long, which causes him to experience pain when being touched on his feet. Resident 45 stated, the facility had never assisted to have his nails trimmed and whenever the staff touched him in his feet, he would scream for pain. During a concurrent interview and record review on 10/23/2024 at 10:53 AM with the Social Service Director (SSD), Resident 45's Podiatric Evaluation and Treatment, dated 10/7/2024, Resident 45's Plan of Care Note, dated 10/11/2024 was reviewed. The SSD stated, according to the Podiatric Evaluation and Treatment, the Podiatrist did not see Resident 45 on 10/7/2024 because Resident 45 refused to be seen. The SSD stated, the document did not indicate if the facility's staff assessed Resident 45 to the reason of refusal and explained to him the risk and benefits for refusal to treatment. The SSD stated, she could not find any care plan and interdisciplinary team (IDT - a coordinated group of experts from several different fields) meeting conducted that addressed Resident 45's refusal to nail care. During an interview on 10/23/2024 at 11:10AM with the Director of Nurses (DON), the DON stated, when Resident 45 refused podiatric care on 10/7/2024, there should be a care plan, and an IDT meeting conducted related to Resident 45's refusal. The DON stated a care plan that address Resident 45's refusal to podiatric care was essential so that staffs knew how to take care of the resident and discussed in the IDT. The DON stated, the resident would not have the right interventions for his refusal to care and staffs would not be able to provide services based on the resident's specific needs. During a review of the facility's P&P titled, Requesting, Refusing, and/or Discontinuing Care or Treatment, dated February 2021, indicated the following: -If a resident/representative requests, discontinues or refuses care or treatment, an appropriate member of the interdisciplinary team (IDT) will meet with the resident/representative to: determine why he or she is requesting, refusing or discontinuing care or treatment; try to address his or her concerns and discuss alternative options; and discuss the potential outcomes or consequences of the decision. -Detailed information relating to the request, refusal or discontinuation of treatment are documented in the resident's medical record.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46779 Based on interview and record review, the facility failed to provide care that meets the professional standards of quality for one of five sampled residents (Resident 72) by failing to: 1. Document - Morphine Sulfate a controlled medication (a drug whose manufacture, possession, or use is regulated by a government) on the Control Drug Record on 10/10/2024 as administered to Resident 72 on her in accordance with the facility's policy and protocol. 2. Document the wrong physician order and wrong volume of receiving medication vial on Resident 72's Control Drug Record. These deficient practices had the potential to result in medication errors, which could lead to adverse reactions (any unexpected or dangerous reaction to a drug) for Resident 72, and undetected diversion (illegal distribution or abuse of prescription drugs or their use for unintended purposes) of controlled medication. Cross reference to F755 Findings: 1.During a review of Resident 72's Admission Record indicated the facility admitted Resident 72 on 6/30/2023 with diagnoses that included dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) and malnutrition (Lack of sufficient nutrients in the body). During a review of Resident 72's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 10/5/2024, indicated Resident 72 had severe cognitive (ability to think and reason) impairment. The MDS indicated Resident 72 required supervision or touching assistance with eating, oral hygiene, and personal hygiene, and partial/moderate assistance with toileting hygiene, shower/bathe self, and chair/bed-to-chair transfer. During a review of Resident 72's Order Summary Report, dated 9/30/2024, indicated the physician ordered to administered Morphine Sulfate (MS, a controlled medication is used to treat moderate to severe pain) Oral Solution 20 milligram (mg, a unit of measurement)/milliliter (ml, a unit of measurement) 0.25 ml (a multidose vial [bottle]) orally in the morning for pain, starting on 7/31/2024. During a review of Resident 72's Medication Administration Record (MAR), dated 10/1/2024 to 10/10/31/2024, indicated Resident 72 received MS 20mg/ml 0.25 ml orally on 10/10/2024. During a concurrent interview and record review on 10/23/2024 at 12:20 PM, with Registered Nurse (RN) 2, Resident 72's Control Drug Record dated 7/31/2024 to 10/9/2024, was reviewed. RN 2 stated Licensed Vocational Nurse (LVN) 4 administered MS 20mg/ml 0.25 ml and documented it on the MAR on 10/10/2024, but LVN 4 did not document in the Control Drug Record that MS 20mg/ml 0.25 ml orally was administered on 10/10/2024. RN 2 stated LVN 4 should have documented that MS 20mg/ml 0.25 ml was administered to Resident 72 on 10/10/2024 to ensure the count for MS was correct. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/23/2024 at 12:35 PM, with the Director of Nursing (DON), the DON stated when the nurse removes a MS from a vial to administer to a resident, the nurse must document on the Controlled Drug Record so that they could keep track on the amount of the MS to prevent medication errors and diversion. During a telephone interview on 10/23/2024 at 1:28 PM, with LVN 4, LVN 4 stated she does not remember if she administered MS to Resident 72 on 10/10/2024. LVN 4 stated according to their facility ' s policy and procedure the nurses are supposed to document the amount of MS that was administered to the resident on the Controlled Drug Record to keep track of the count on controlled medications. 2. During a review of Resident 72's Controlled Drug Record for MS, dated 7/31/2024 to 10/9/2024, indicated Morphine Sulfate 100mg/5ml Conc. Give 0.25 under tongue Q (every) 4 PRN (as needed) for severe pain. The Controlled Drug Record indicated the MS vial contained 30 ml. During a review of Resident 72's MS Pharmacy Delivery Receipt, dated 7/29/2024, indicated MS 100mg/5ml in a quantity of 15 (unknown number if dosage or vial count) was delivered on 7/29/2024 at 9:09 PM. During a review of Resident 72's MS Pharmacy Delivery Receipt, dated 8/22/2024, indicated MS 100mg/5ml in a quantity of 3.75 (unknown number if dosage or vial count) was delivered on 8/22/2024 at 12:33 PM. During a review of Resident 72's MS Pharmacy Delivery Receipt, dated 9/5/2024, indicated MS 100mg/5ml in a quantity of 3.75 (unknown number if dosage or vial count) was delivered on 9/5/2024 at 2:10 PM. During an interview and record review on 10/23/2024 at 12:36 PM, with RN 1, RN 1 stated Resident 72 was receiving MS 20mg/ml 0.25ml daily since 7/31/2024. RN 1 stated there was no Physican order to administer MS every four hours as needed. RN 1 stated the instruction for the use of MS on Resident 72's Controlled Drug Record was incorrect. RN 1 stated the nurse who received the delivery of MS vials should have verified the instruction on the Controlled Drug Record by checking the physician order and the MS Pharmacy Delivery receipts. RN 1 stated if the nurse saw a discrepancy on the MS Pharmacy Delivery receipts and the physician's orders, and the nurse must clarify the order and correct the Controlled Drug Record. During a telephone interview on 10/24/2024 at 12:17 PM, with Pharmacist 1, Pharmacist 1 stated the pharmacy delivered MS 100mg/5ml in a quantity of 15 ml to the facility on [DATE], 3.75 ml on 8/22/2024, and 3.75 ml on 9/5/2024. During an interview on 10/24/2024 at 4:40 PM, with the DON, the DON stated the receiving volume of MS on Resident 72's Controlled Drug Record was incorrect. The DON stated the nurse who received the MS should write down 15 ml instead of 30 ml on the Controlled Drug Record. The DON stated the pharmacy delivered the MS one bottle at a time for three times on 7/29/2024, 8/22/2024 and 9/5/20204, and the nurse should have created three separate Controlled Drug Records for the MS they received on 7/29/2024, 8/22/2024 and 9/5/2024. The nurse should check the physician order, the medications that received, and the Controlled Drug Record to make sure the instruction and the received amount of the medication were correct to prevent medication errors and diversion of controlled medications. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, reconciliation of Medication on Admission, dated 7/2017, indicated If there is a discrepancy or conflict in medications, dose, route or frequency, determine the most appropriate action to resolve the discrepancy. During a review of the facility's P&P titled, Controlled Substances, dated 11/2022, indicated once controlled substance was delivered and the count is correct, an individual resident-controlled substance record is made for each resident who will be receiving a controlled substance. Do not enter more than one prescription per page. This record contains: .Quantity received; number on hand, time of administration, and Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loos/diversion and detection/follow-up.

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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** 46779 Based on observation, interview, and record review, the facility failed to ensure proper footwear for one of two sampled residents (Resident 76). This deficient practice had the potential to result in Resident 76's discomfort and placed Resident 76 at risk for falls and injuries. Findings: During a review of Resident 76's Admission Record indicated the facility originally admitted Resident 76 on 2/26/2024 and readmitted on [DATE] with diagnoses that included diabetes mellitus (a group of diseases that affect how the body uses blood sugar) and cellulitis (a deep infection of the skin caused by bacteria) of right lower limb During a review of Resident 76's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/12/2024, indicated Resident 76 had moderate memory and cognitive (ability to think and reasonably) impairment. The MDS indicated Resident 76 required setup or clean-up assistance with eating, supervision or touching assistance with oral hygiene, partial/moderate assistance with toileting hygiene, shower/bathe self, personal hygiene, and chair/bed-to-chair transfer. During a review of Resident 76's Discharge Summary 2 from the General Acute Care Hospital (GACH), dated 6/8/2024, indicated Resident 76 was placed in a surgical shoe after a surgery performed on 6/6/2024. During a review of Resident 76's Fall Risk Evaluation, dated 8/18/2024, indicated Resident 76 had one to two falls in the past three months, and that Resident 76 was at risk for falls. During a review of Resident 76's Order Summary Report, dated 10/1/2024, indicated the physician ordered for Resident 76's ulcers (an open sore or wound that develops on the skin) at the right 5th toe and right great toe, to cleanse with normal saline (a mixture of water and salt), pat dry, apply mupirocin two percent ointment (a medication to treat skin infections and cover with abdominal (relating to belly) pad, wrap with roll bandage daily. During an observation on 10/21/2024 at 9:07 AM, in Resident 76's room, Resident 76 was observed lying in bed and her right foot was wrapped with gauze (a thin, translucent fabric with a loose open weave). A pair of gray-colored open toe Velcro strap slippers were on the floor at the right side of the bed. The Velcro on the right side of the slippers was taped with a piece of duct tape. During an interview on 10/21/2024 at 11:32 AM, Resident 76 stated she had wounds on her right foot and that her foot was wrapped in gauze. Resident 76 stated she could not put on the right side of the slippers because the strap was too tight. Resident 76 stated family member (FM) 1 opened the Velcro strap and taped a piece of duct tape over the Velcro strap so that Resident 76 could have more room in the slipper so that the right foot slipper would fit properly. Resident 76 stated she had been wearing the duct-taped slipper for two months now. Resident 76 stated she wanted to wear shoes because she wanted to feel comfortable and did not want to get the gauze on her right foot dirty. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/21/2024 at 11:37 AM, with the certified Nursing Assistant (CNA) 2, CNA 2 stated she seen Resident 76 wearing the slippers that was duct taped. CNA 2 stated Resident 76's family member placed the duct tape on Resident 76's slipper and CNA 2 did not see any concern with the duct-taped slippers worn by Resident 76. CNA 2 stated it was safe for Resident 76 to wear the duct-taped slipper. During an interview on 10/21/2024 at 12:41 PM, with Physical Therapist (PT) 1, PT 1 stated Resident 76's right side of the slippers, that was secured with a piece of duct tape at the Velcro strap, was not safe for Resident 76 to wear. PT 1 stated Resident 76 should wear the post-op shoe (surgical shoes or medical shoes, are designed to minimize harm and feature highly adjustable strapping systems, which enable the shoe to accommodate swelling and bandaging that could not fit inside a normal shoe). PT 1 stated the duct tape could get ripped and torn when Resident 76 was wearing it, leading to potential falls and injuries. PT 1 stated he was supposed to conduct a Joint Mobility Assessment upon each return of Resident 76 to the facility to screen her rehabilitative needs. PT 1 stated he did not pay attention to Resident 76's footwear and did not know for how long Resident 76 had worn the duct-taped slipper. During an interview on 10/21/2024 at 3:55 PM, with the Treatment Nurse (TXN), the TXN stated he provided wound care to Resident 76's right foot every day and he stated he did not notice what Resident 76 was wearing as her footwear. The TXN stated Resident 76 had a post-op shoe after her surgery in 6/2024, but he did not know where her post-op shoe was and for how long Resident 76 had worn the duct-taped slipper. The TXN stated the duct-taped slipper was not comfortable and not safe for Resident 76 to wear. The TXN stated the staff should have assessed Resident 76 and provided an appropriate shoe to her ensure comfort and safety. During an interview on 10/24/2024 at 8:45 AM, with FM 1, FM 1 stated Resident 76 had a post-op shoe for her right foot after her surgery in 6/2024. FM 1 stated the post- op shoe was missing. FM 1 stated he saw Resident 76 did not have shoes to wear in the facility about two months ago, so he bought a pair of slippers for her. FM 1 stated Resident 76 had a thick bandage around her right foot and the right side of the slipper did not fit, so he opened the Velcro strap and duct-taped it for Resident 76 to wear. FM 1 stated he was not a medical person, and he did not know what Resident 76 needed to protect her foot, but the facility staff did not mention and did not provide the proper footwear to Resident 76. During an interview on 10/24/2024 at 4:45 PM, the DON stated the staff should have assessed Residents 76's needs and provided the resident the appropriate footwear to ensure comfort and safety. During a review of the facility's policy and procedure (P&P) titled, Foot Care, dated 10/2022, indicated Residents receive appropriate care and treatment in order to maintain mobility and foot health. During a review of the facility's P&P titled, Falls and Fall Risk, Managing, dated 3/2018, indicated the staff should identify the resident's specific fall risk factors, including footwear that is unsafe or absent.

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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** 50012 Based on interview and record review, the facility failed to ensure residents who were at risk for skin breakdown and pressure injuries (localized damage to the skin and underlying soft tissue, usually occurring over a bony prominence or related to medical devices) received treatment and services to prevent skin breakdown for one of three sampled residents (Resident 21) with pressure injury by failing to ensure the low air loss mattress (LAL Mattress -air filled mattress used to relieve pressure) was set according to resident's weight. Resident 21's LAL mattress was set for 320 pounds (lbs.) body weight instead of 200 lbs. body weight since Resident 21's weigh was 185 lbs. As a result of this deficient practice Resident 21 was at a potential risk for developing pressure injury and/or worsened pressure injury to both heels. Findings: During a review of Resident 21's Admission Record (Face Sheet), dated 4/6/2023, the face sheet indicated the facility admitted Resident 4 on 4/6/2023, and readmitted on [DATE] with diagnoses including peripheral vascular disease (narrowing and hardening of the arteries in the legs and feet), Diabetes type 2 (high blood sugar). During a review of Resident 21's History and Physical (H&P), dated 1/11/2024, indicated, Resident 21 did not have the mental capacity to make medical decisions. During a review of Resident 21's Order Summary Report, dated 6/3/2024 indicated low air loss mattress (LAL Mattress) monitor setting, placement, and functioning q-shift daily- every shift. During a review of Resident 21's Minimum Data Set (MDS-a federally mandated resident assessment tool.), dated 7/25/2024, indicated has severe cognitive impairment (the ability to think and process information). The MDS indicated the resident required substantial/maximal assistance (helper does more than half the effort, lifts or holds trunk or limbs) for toilet use and transfers, was not able to walk, and needed extensive assistance with bed mobility, personal hygiene, and dressing. During a review of Resident 21's Weight records, for 2024, indicated Resident 21's weight 185 pounds (lbs. -unit of measurement) for the 10/3/2024. During an observation on 10/21/2024 at 10:40 AM, Resident 21 was observed with a LAL Mattress was set for a person weighing 320 lbs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/22/2024 at 2:20 PM with Treatment Nurse (TXN), indicated Resident 21's Weight Summary, dated 10/3/2024, was 185 lbs. TXN stated the LAL Mattress setting for Resident 21 was not set correctly so the air could be distributed correctly. TXN stated that if the LAL mattress was not set correctly, it can give more pressure on the wound and be harmful instead of beneficial to the resident. TXN stated the LAL Mattress setting for Resident 21 should be at 200 lbs. since Resident 21's weigh was 185 lbs. TXN stated incorrect settings of LAL mattress places the resident at higher risk for further skin breakdown. During a review of the facility's policy and procedure (P&P) titled, Pressure Ulcers/Skin Breakdown-Clinical Protocol, revised 2018, indicated the physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.), and application of topical agents. During a review of Low Air Loss Mattress Owner's Manual indicated, Protek Are 3000 pump and mattress system, is indicated for the prevention and treatment of all stage pressure ulcers when used in conjunction with a comprehensive pressure ulcer management program. The owner's manual also indicated to determine the patient's weight and set the control knob to the weight setting on the control unit.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on observation, interview and record review, the facility failed to provide foot care for one of three sampled residents (Resident 45) with long nails and [NAME] infection and was documented by the facility as the resident refused podiatric (a physician specialized in foot treatment) treatment and no alternative services were offered or provided to ensure foot care was provided. Resident 45 stated he was never asked and provided foot and nails care by the facility's staff. This deficient practice resulted in Resident 45's feeling pain and uncomfortable when his feet were being touched and had a potential to result in worsened foot infection. Cross Reference to F656. Findings: During a review of Resident 45's Admission Record, indicated Resident 45 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included paraplegia (chronic condition that refers to the loss of muscle function in the lower half of the body, including the legs and sometimes the abdomen), primary osteoarthritis (arthritis that occurs when flexible tissue at the ends of bones wears down). During a review of Resident 45's Order Summary Report, indicated on 3/18/2024 Resident 45 had a physician order for podiatry care (a physician specialized in treating foot care) every 60-90 days as needed for mycotic (a fungal infection that affects the fingernails or toenails), hypertrophic (the abnormal enlargement) toenails and/or foot problems. During a review of Resident 45's History and Physical (H&P), dated 7/27/2024, indicated Resident 45 had the capacity to understand and make decisions. During a review of Resident 45's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/25/2024, indicated Resident 45 ' s cognition (ability to think, remember, and reason with no difficulty) was intact, and needed moderate assistance for personal hygiene. During a review of Resident 45's Patient Care Plan: ADL (Activities of Daily Living, the basic tasks people need to do to care for themselves, such as eating, dressing, and using the toilet) Function, dated 7/25/2024, indicated Resident 45 had ADL deficit related to extensive assistance in personal hygiene, the goal was that the resident would be able to groom daily, and the interventions included to assist with ADL as needed. During a review of Resident 45's Plan of Care Note, dated 10/11/2024, indicated Resident 45 refused to be seen by Podiatry on 10/7/2024. During a review of Resident 45's Podiatric Evaluation and Treatment, dated 10/7/2024, indicated no podiatric evaluation and treatment completed due to Resident 45's refusal. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 10/21/2024 at 10:11 AM in Resident 45's room, Resident 45's left and right big toe ' nails were measured approximately one inch per toenail. Resident 45 stated, he needed his toenails clipped because it was very uncomfortable to have them long. During a concurrent observation and interview on 10/23/2024 at 10:24 AM in Resident 45's room, Resident 45's left and right big toe' nails were observed approximately one inch toenail. Resident 45 stated, his toenails were too long, which caused him to experience pain when being touched on his feet. Resident 45 stated, the facility had never assisted to have his nails trimmed and whenever the staff touched him in his feet, he would scream for pain. During an interview on 10/23/2024 at 1 PM with Certified Nurse Assistant (CNA) 5, CNA 5 stated, she noticed that Resident 45's big toenails were long. CNA 5 stated, she did not report it to the Charge Nurse because the Social Service Director (SSD) usually took care of the nail trimming. During an interview on 10/23/2024 at 10:35 AM with the Licensed Vocational Nurse (LVN 3), LVN 3 stated, she was not aware that Resident 45's toenails were long. LVN 3 stated, she should have assessed and asked if Resident 45 needed his toenails trimmed and followed up with the SSD needed. During a concurrent observation and interview on 10/23/2024 at 10:48 AM with the Social Service Designee (SSD) in Resident 45's room, when the SSD asked if Resident 45 needed his big toenails trimmed, Resident 45 stated, yes, of course. During a concurrent interview and record review on 10/23/2024 at 10:53 AM with the SSD, Resident 45's Podiatric Evaluation and Treatment, dated 10/7/2024, Resident 45's Plan of Care Note, dated 10/11/2024 was reviewed. The SSD stated, according to the review of the record, the Podiatrist did not see Resident 45 on 10/7/2024 because Resident 45 refused to be seen. The SSD stated, the document did not indicate if the facility's staff assessed Resident 45 to the reason of refusal and explained to him the risk and benefits for refusal to treatment. The SSD stated, she did not know Resident 45 refused his toenails to be trimmed due to pain. The SSD stated, she could not find any care plan and interdisciplinary team (IDT - a coordinated group of experts from several different fields) meeting conducted that addressed Resident 45's refusal to nail care. During an interview on 10/23/2024 at 11:10AM with the Director of Nurses (DON), the DON stated, when Resident 45 refused podiatric care on 10/7/2024, the SSD should have assessed Resident 45 explained the purpose of treatment, the risk of refusal and assessed the reason why Resident 45 refused care. The DON stated, without addressing the reason for refusal, Resident 45 did not get the care he needed. The DON stated the CNAs were supposed to report her findings of Resident 45 ' s long toenails to the LVN and the LVN supposed to follow up with the SSD to make sure nail care was given to Resident 45. During a review of the facility's policy and procedure (P&P) titled, Activities of Daily Living (ADL), Supporting, dated March 2018, indicated residents who are unable to carry out ADL independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. During a review of the facility's P&P titled, Foot Care, dated October 2022, indicated residents receive appropriate care and treatment in order to maintain mobility and foot health. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Requesting, Refusing, and/or Discontinuing Care or Treatment, dated February 2021, indicated the following: -If a resident/representative requests, discontinues or refuses care or treatment, n appropriate member of the interdisciplinary team (IDT) will meet with the resident/representative to: determine why he or she is requesting, refusing or discontinuing care or treatment; try to address his or her concerns and discuss alternative options; and discuss the potential outcomes or consequences of the decision. -Detailed information relating to the request, refusal or discontinuation of treatment are documented in the resident's medical record.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 47467 Based on observations, interviews and record reviews, the facility failed to implement the facility ' s policy and procedure (P&P) titled, Smoking Policy-Residents, dated 8/2022, to ensure eight of eight sampled residents (Residents 2, 3, 9, 14, 18, 56, 67 and 136) who were smokers (residents who smoked cigarettes) had an environment free of accident hazards (risk) by failing to: 1. Provide supervision while smoking to Residents 2, 3, 9, 14, 18, 56, 67 and 136 when Resident 2, 3, 14, 18, 56, 67 and 136, were assessed by the facility as unsafe smokers, and when Resident 9 ' s smoking assessment was not completed by the facility. 2. Ensure Resident 9 was assessed for the level of supervision while smoking. 3. Ensure Resident 3 did not store cigarettes and lighters in Resident 3 ' s drawer. 4. Ensure Resident 14, who was assessed by the facility as unable to light tobacco [a preparation of the nicotine (a toxic colorless or yellowish oily liquid that is the chief active constituent of tobacco) rich leaves of an American plant, which are cured by a process of drying and fermentation for smoking or chewing safely, did not pass/share cigarettes with Residents 9, 56 and 136, and used Resident 67 ' s lighter to light cigarettes. 5. Ensure Receptionist (REC) 1 did not provide lit cigarettes and allowed Residents 9 and 14 to smoke unsupervised during nonscheduled smoking time. 6. Identify Residents 2, 9, 14, 18 and 136 as noncompliant with the facility ' s smoking policy when Residents 2, 9, 14, 18 and 136 smoked during nonscheduled smoking time. 7. Ensure Residents 3, 56 and 67 who were identified as non-compliant with facility ' s smoking policy, were not allowed by the facility to continue to keep cigarettes and lighters in Resident 3, 56 and 67 ' s possession. 8. Ensure a designated staff was scheduled to supervise the smoking patio area during the scheduled and nonscheduled smoking time. 9. Ensure the facility has a plan of action in place on how to care for residents who did not comply with the facility ' s smoking policy. These deficient practices had the potential for Residents 2, 3, 9, 14, 18, 56, 67 and 136 to be at risk for accidental burn, fire hazards that could affect the health, safety, wellbeing of residents, staffs, visitors and result in serious injuries, hospitalization and death. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On October 22, 2024, at 3:32 PM, while onsite at the facility, the California Department of Public Health (CDPH) identified an Immediate Jeopardy situation (IJ, a situation in which the provider ' s noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death of a resident) regarding the facility ' s failure to prevent smoking hazards by not monitoring and supervising smoking activities for Residents 2, 3, 9, 14, 18, 56, 67 and 136. The facility also failed to safely secure/store lighters and cigarettes. On 10/24/2024 at 1:42 PM, the IJ was removed in the presence of the Director of Nurses (DON, who was covering and acting as the facility ' s Administrator), Quality Assurance Consultant 1, and Clinical Consultant 1 after the facility submitted an acceptable IJ Removal Plan (a plan that identifies all actions the facility will take to immediately address the noncompliance that has resulted in the IJ situation) and while onsite at the facility, the surveyors verified/confirmed the facility ' s implementation of the IJ Removal Plan and the IJ situation was no longer present. The facility had a plan in place to supervise all smokers. The IJ Removal Plan dated 10/24/2024, included the following: 1. On 10/21/2024 at around 5 PM, Residents 3, 56 and 67 ' s two packs of cigarettes and lighter were taken from Residents 3, 56 and 67 ' s bedside drawers by the DON and kept in the locked drawer in the receptionist desk. 2. On 10/21/2024 at around 5 PM, Resident 67 was provided education by the Social Service Director (SSD), and the DON regarding facility staff keeping the smoking materials and Resident 67 would not smoke without any supervision by the facility staff. Resident 67 agreed to comply with the facility staff after discussion with Resident 67. The facility ' s receptionist would be the keeper of the smoking items and smoking materials. Only staff would have access to the keys of the smoking items. 3. On 10/21/2024 at around 5 PM, Resident 3 was educated by the SSD on the facility ' s smoking P&P including surrendering cigarettes and smoking materials to facility staff. 4. On 10/21/24 Residents 3 and 56 ' s Care Plans (CPs, a document that outlines the facility ' s plan to provide personalized care to a resident based on the resident ' s needs) for smoking were updated by the licensed nurses indicating the interventions for Resident 3 and 56 to safety smoke, and the DON initiated additional CPs for Resident 3 and 56 ' s non-compliance with smoking per P&P. 5. On 10/21/2022 Resident 136 was transferred to the General Acute Hospital (GACH) and would be re-educated by the SSD or designee regarding the facility ' s smoking P&P including not giving and not receiving cigarettes from other residents. 6. On 10/22/24 the smoking attendants were provided education by the DON/Designee on the facility ' s smoking P&P regarding the importance of supervision and being on the designated smoking area during smoking schedule. No smoking attendant would be assigned as a smoking attendant without being educated on the importance of being at smoking area during smoking schedule. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	7. On 10/22/24, the facility implemented dedicated smoking attendants to monitor smokers 24 hours a day during scheduled and nonscheduled smoking times. The Activities Director (AD)/designee was responsible to schedule the smoking attendants weekly or as needed. The dedicated smoking attendant would log the behavior of the identified non-compliant residents and would intervene accordingly if residents found to not following the facility ' s P&P such as smoking on nonscheduled times or having in possession smoking paraphernalia (any device used, intended for use, or designed for use in smoking) when inside or outside the facility. 8. On 10/22/2024, Residents 2, 9, 14, and 18 ' s CPs were updated to reflect smoking non-compliance. 9. On 10/22/2024 at around 6 PM, Resident 9 was re-educated regarding the facility ' s P&P for smoking including lighting cigarettes in the smoking area by the delegated smoking supervisor. 10. On 10/22/2024, around 6 PM, Residents 3 and 56 were provided education by the SSD about safety on smoking and not to smoke without any supervision by staff. 11. On 10/24/2024, Resident 14 was re-educated by the SSD regarding the facility ' s smoking P&P including not giving and not receiving cigarettes from other residents. 12. On 10/24/2024, REC 1 was provided a 1:1 (a direct encounter between 2 persons) in-service by the DON regarding the facility ' s new smoking P&P including supervision of smokers. 13. On 10/24/2024, the SSD and Interdisciplinary Team (IDT, a team of people from different disciplines who work together to improve patient/resident care) members initiated a discussion with all residents who smoke (not limited to Residents 3 and 56) regarding the facility ' s P&P on smoking and importance of adhering to the policy for safety. Residents 3 and 56 agreed on complying on 10/24/2024 per IDT discussion. 14. On 10/24/2024, the quality Assessment and Assurance Committee (QAA, committee established for the purpose of improving the safety and quality of health services) members with the medical director and administrator updated the smoking policy with the policy not limited to addressing supervision of smokers and indicating potential outcomes for the non-compliant smokers. 15. On 10/24/2024, the DSD/designee initiated an in-service to licensed, non-licensed staff and smoking attendants on the importance of ensuring supervision of smokers In-service to all staff would be continued until all smoking attendants that would l be scheduled were provided education on supervision. Total of 8 residents were observed non-compliant with the facility ' s smoking policy and procedure. The facility ' s census was 84 and there were 23 smokers. Findings: a. During a review of Resident 2's Admission Record (AR), the AR indicated the facility admitted Resident 2 on 6/23/2016 and readmitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD, a lung disease characterized by long-term poor airflow) and nicotine dependence, cigarettes (occurs when the resident needed nicotine and could stop using it). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of Resident 2 ' s History and Physical (H&P, a comprehensive physician ' s note regarding the assessment of the resident ' s health status), dated 12/29/2023, the H&P indicated, Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2 ' s Order Summary Report (OSR), the OSR indicated on 12/16/2023, Resident 2 had a physician order that Resident 2 may smoke cigarette per preference with staff supervision in designated smoking area and in accordance with facility ' s smoking policy. During a review of Resident 2 ' s Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/15/2024, the MDS indicated Resident 2 ' s cognition (ability to think, remember, and reason) was severely impaired, and Resident 2 needed supervision in walking 150 feet in a corridor or similar space. During a review of Resident 2 ' s Smoking and Safety (S&S), dated 8/15/2024, the form indicated Resident 2 was a tobacco user. During a review of Resident 2 ' s CP, titled Smoking, dated 8/27/2024, the CP indicated Resident 2 was at risk for hazard/injury (burns) related to smoking cigarettes. The interventions included for facility staff to provide frequent monitoring to Resident 2 during smoking times. b. During a review of Resident 3's AR, the AR indicated the facility admitted Resident 3 on 10/10/2017 and readmitted on [DATE] with diagnoses that included hemiplegia [a condition that causes half of the body to be paralyzed (or unable to move)] and hemiparesis (weakness or the inability to move on one side of the body) following cerebral infarction (or a stroke, which is a medical emergency that occurs when blood flow to the brain is cut off) affecting right dominant side, and COPD. During a review of Resident 3 ' s OSR, the OSR indicated on 5/6/2024, Resident 3 had a physician order that Resident 3 may smoke cigarette per preference with staff supervision in designated smoking area and in accordance with facility ' s smoking policy. During a review of Resident 3 ' s H&P, dated 5/8/2024, the H&P indicated Resident 3 had the capacity to understand and make decisions. During a review of Resident 3 ' s MDS, dated [DATE], the MDS indicated Resident 3 ' s cognition was intact. The MDS indicated Resident 3 was a tobacco user, and able to independently (resident completes the activity by themselves with no assistance from a helper) utilize the wheelchair to manually wheel at least 50 feet, make two turns or at least 150 feet in a corridor or similar space. During a review of Resident 3 ' s S&S, dated 9/6/2024, the S&S indicated Resident 3 had balance problems while sitting or standing, and required supervision during smoking breaks. The form indicated the goal was for Resident 3 to adhere to the facility ' s Tobacco/Smoking Policies. During a review of Resident 3 ' s CP titled, Smoking, dated 10/2024, the CP indicated Resident 3 was at risk for discomfort, shortness of breath (SOB, the feeling of not get enough air into the lungs) and injury related to smoking. The interventions included for facility staff to provide frequent monitoring, remind Resident 3 of smoking schedule, and reorient Resident 3 to the smoking area. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of Resident 3 ' s CP, tilted Non-Compliance with Smoking, dated 10/2024, the CP indicated Resident 3 was not following smoking schedule and was keeping/hiding smoking paraphernalia such as lighters, matches and at risk for injury related to smoking and non-compliance behavior. The interventions included for staff to conduct an IDT conference with Resident 3 and for facility staff to supervise designated smoking area. c. During a review of Resident 9's AR, the AR indicated the facility admitted Resident 9 on 6/24/2019 with diagnoses that included COPD, and arthritis [the swelling and tenderness of one or more joints (places where two bones meet, such as the elbow or knee)]. During a review of Resident 9 ' s OSR, indicated on 7/11/2019, Resident 9 had a physician order that Resident 9 may smoke cigarette per preference with staff supervision in designated smoking area and in accordance with facility ' s smoking policy. During a review of Resident 9 ' s MDS, dated [DATE], the MDS indicated Resident 9 ' s cognition was intact, and Resident 9 was able to wheel the wheelchair at least 150 feet in a corridor or similar space. During a review of Resident 9 ' s S&S, dated 6/3/2024, the S&S indicated Resident 9 was a tobacco user and the CP ' s goal was for the resident to adhere to the facility ' s Tobacco/Smoking Policies. d. During a review of Resident 14's AR, the AR indicated the facility admitted Resident 14 on 1/13/2020 and readmitted on [DATE] with diagnoses that included COPD, and nicotine dependence, cigarettes. During a review of Resident 14 ' s OSR, dated on 5/30/2014, the OSR indicated Resident 14 had a physician order that Resident 14 may smoke cigarette per preference with staff supervision in designated smoking area and in accordance with facility ' s smoking policy. During a review of Resident 14 ' s MDS, dated [DATE], the MDS indicated Resident 14 ' s cognition was intact, and Resident 14 needed supervision in walking 150 feet in a corridor or similar space. During a review of Resident 14 ' s S&S, dated 8/22/2024, the S&S indicated Resident 14 was a tobacco user. The form indicated Resident 14 was unable to light tobacco safely, and Resident 14 required supervision during smoking breaks. e. During a review of Resident 18's AR, the AR indicated the facility admitted Resident 18 on 7/6/2017 and readmitted on [DATE] with diagnoses that included COPD, and nicotine dependence, cigarettes. During a review of Resident 18 ' s OSR, dated 4/7/2023, the OSR indicated Resident 18 had a physician order that Resident 18 may smoke cigarette per preference with staff supervision in designated smoking area and in accordance with facility ' s smoking policy. During a review of Resident 18 ' s MDS, dated [DATE], the MDS indicated Resident 18 ' s cognition was intact. The MDS indicated Resident 18 was a tobacco user and was able to utilize the wheelchair with supervision to wheel at east 150 feet in a corridor or similar space. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of Resident 18 ' s H&P, dated 4/4/2024, the H&P indicated Resident 18 had the capacity to understand and make decisions. During a review of Resident 18 ' s S&S, dated 8/14/2024, the S&S indicated Resident 18 was a tobacco user, and Resident 18 had balance problems while sitting or standing. During a review of Resident 18 ' s CP titled, Smoking, dated 8/16/2024, the CP indicated Resident 18 was at risk for hazards/injury (burns) related to smoking cigarettes. The interventions included for facility staff to provide frequent monitoring to Resident 18 during smoking times. f. During a review of Resident 56's AR, the AR indicated the facility admitted Resident 56 on 4/10/2024 with diagnoses that included nicotine dependence, cigarettes, and psychoactive substance (a drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) abuse. During a review of Resident 56 ' s OSR, dated 4/10/2024, the OSR indicated Resident 56 had a physician order that Resident 56 may smoke cigarette per preference with staff supervision in designated smoking area and in accordance with facility ' s smoking policy. During a review of Resident 56 ' s H&P, dated 4/10/2024, the H&P indicated Resident 56 was a smoker, and had the capacity to understand and make decisions. During a review of Resident 56 ' s MDS, dated [DATE], indicated Resident 56 ' s cognition was intact. The MDS indicated Resident 56 needed supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) when walking 150 feet in a corridor or similar space. During a review of Resident 56 ' s CP titled, Smoking, dated 4/10/2024, the CP indicated Resident 56 was at risk for discomfort, SOB and injury related to smoking. The interventions included for staff to frequent monitoring Resident 56 while smoking, remind Resident 56 of smoking schedule, and to wear smoking apron. During a review of Resident 56 ' s Activity Participation Notes, dated 9/23/2024, the notes indicated Resident 56 was noncompliant with Smoking Policy and Procedure. The notes indicated Resident 56 smoked whenever and wherever Resident 56 wanted, and Resident 56 continued to supply cigarettes to other residents. The notes indicated Resident 56 declined to surrender smoking paraphernalia like lighters and cigarettes. During a review of Resident 56 ' s S&S, dated 10/16/2024, the S&S indicated Resident 56 was a tobacco user and was noncompliant with smoking times. g. During a review of Resident 67's AR, the AR indicated the facility admitted Resident 67 on 4/18/2024 with diagnoses that included COPD due to drugs, and nicotine dependence, cigarettes. During a review of Resident 67 ' s H&P, dated 7/5/2024, the H&P indicated Resident 67 had a smoking history, and had the capacity to understand and make decisions. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of Resident 67 ' s S&S, dated 7/25/2024, the S&S indicated Resident 67 was a tobacco user. The S&S indicated Resident 67 had balance problems while sitting or standing, and required supervision during smoking. During a review of Resident 67 ' s CP titled, Smoking, dated 7/5/2024, the CP indicated Resident 67 was at risk for discomfort, SOB and injury related to smoking. The interventions included for facility staff to provide frequent monitoring, reorienting Resident 67 to the smoking area, and offering smoking apron. During a review of Resident 67 ' s IDT Care Conference notes, dated 7/30/2024, the notes indicated the IDT met with Resident 67 regarding the smoking P&P. The notes indicated Resident 67 was re-educated and the resident agreed to comply with the smoking scheduled time. The notes indicated Resident 67 was reminded that any smoking paraphernalia should be surrendered to the activity staff, including cigarettes and lighters for safekeeping. During a review of Resident 67 ' s CP titled, Noncompliance with Smoking, dated 8/1/2024, the CP indicated Resident 67 did not follow the facility ' s smoking schedule. The CP indicated Resident 67 shared/passed only one cigarette and smoked the same cigarette with other residents. The CP indicated Resident 67 was at high risk for transmitting infection. The interventions included for facility staff to supervise designated smoking area, offer smoking apron every schedule smoking time to Resident 67, and notify Resident 67 ' s Medical Doctor (MD) about Resident 67 ' s non-compliance. During a review of Resident 67 ' s Activity Participation Notes, dated 9/23/2024, the notes indicated Resident 67 was noncompliant with Smoking P&P. The notes indicated Resident 67 smoked whenever and wherever she wanted. The notes indicated Resident 67 continued to supply cigarettes to other residents and declined to surrender smoking paraphernalia like lighters and cigarettes. During a review of Resident 67 ' s MDS, dated [DATE], the MDS indicated Resident 67 ' s cognition was moderately impaired. The MDS indicated Resident 67, needed supervision in walking 150 feet in a corridor or similar space. h. During a review of Resident 136's AR, the AR, indicated the facility admitted Resident 136 on 10/1/2024 and readmitted on [DATE] with diagnoses that included lack of coordination, drug induced secondary parkinsonism (condition that manifested by tremors, muscle stiffness and slow movement), and hypertension (high blood pressure). During a review of Resident 136 ' s H&P, dated 10/2/2024, the H&P indicated Resident 136 had the capacity to understand and make decisions. During a review of Resident 136 ' s MDS, dated [DATE], the MDS indicated Resident 136 ' s cognition was moderately impaired. The MDS indicated Resident 136 needed partial assistance (helper does less than half the effort) in walking at least 10 feet in a room, corridor, or similar space. During a review of Resident 136 ' s OSR, dated 10/17/2024, the OSR indicated Resident 136 had a physician order that Resident 136 may smoke cigarette per preference with staff supervision in designated smoking area and in accordance with facility ' s smoking policy. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of Resident 136 ' s S&S, dated 10/17/2024, the S&S indicated Resident 136 was a tobacco user. The S&S indicated Resident 136 had balance problems while sitting or standing, and Resident 136 needed staff supervision during smoking hours. During a concurrent observation and interviews on 10/21/2024 at 10:34 AM with Residents 14 and 136 in the smoking area, Residents 14 and 136 were smoking during nonscheduled smoking time. The Smoking time/schedule sign were as follows: 8AM-9AM, 1PM-2PM, 6PM-7PM. Resident 136 stated, Resident 136 could smoke anytime he wanted. Resident 136 stated, Resident 14 gave Resident 136 cigarettes. Resident 136 stated, Resident 14 lit the cigarettes for Resident 136. Resident 14 stated, Resident 14 got the cigarettes and lighter from REC 1 at the front desk. During a concurrent observation and interview on 10/21/2024 at 10:46 AM with Resident 14, Resident 14 walked out of the facility ' s entrance door with a lit cigarette in Resident 14 ' s hand and smoked his cigarette approximately 10 feet away from the designated smoking area in the patio without any staff supervision. Resident 14 stated, he received the cigarette from REC 1. After smoking a cigarette, Resident 14 threw the cigarette butt on the ground and stamped on the lit cigarette with Resident 14 ' s right foot instead of disposing the lit cigarette in the designated smoking receptacle (container or device used to extinguish and dispose of cigarette waste). During an observation on 10/21/2024 at 11:10 AM in the smoking area, seven (7) residents including Resident 18 were smoking in the patio during nonscheduled smoking time without a staff supervising the residents. During an observation on 10/21/2024 at 12:05 PM in Resident 14 ' s room, Resident 14 was holding a full pack of cigarettes. During an observation on 10/21/2024 from 1PM to 2PM (scheduled smoking time) in the facility ' s designated smoking area, Residents 2, 9, 14, 18 and 136 were smoking without a staff supervising the residents. During an observation on 10/21/2024 at 3:09 PM (nonscheduled smoking time) in the patio, Resident 9 was smoking with no staff presented to supervise the resident. Resident 9 pointed to REC 1 and stated Resident 9 received his lit cigarette from REC 1 who was sitting at the front desk inside the facility. During a concurrent observation and interview on 10/21/2024 at 3:10 PM in the facility ' s designated smoking area with Resident 56, Resident 56 threw Resident 56 ' s cigarette butt behind the planter and took Resident 14 ' s cigarette after Resident 14 offered a lit cigarette to Resident 56. Resident 56 stated, Resident 56 had his own cigarette lighter since admission and Resident 56 kept the lighter in his pant pocket. During an observation on 10/21/2024 at 3:12 PM (nonscheduled smoking time) in the patio, Residents 2, 14, and 67 with five (5) other residents were smoking without any staff to supervise the residents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a concurrent observation and interview on 10/21/2024 at 3:15 PM (nonscheduled smoking time) with Resident 67 and Resident 14 in the patio, Resident 67 was sitting on a wheelchair smoking with no staff supervision, Resident 67 ' s cigarette ashes dropped down on Resident 67 ' s clothes from the top part of Resident 67 ' s chest to the resident ' s waist. One blue cigarette lighter was observed on top of a napkin in Resident 67 ' s wheelchair ' s cup holder. Resident 67 stated, she usually smoked one to one and a half pack of cigarettes per day and Resident 67 could smoke anytime she wanted. Resident 67 stated, she kept a lighter within her possession since she was admitted to the facility. Resident 14 stated he used Resident 67 ' s lighter to light his cigarettes. During an interview on 10/21/2024 at 3:20PM with REC 1, REC 1 stated, the designated smoking area was right outside of the facility ' s entrance. REC 1 stated, he was assigned to give out lit cigarettes to the smokers and watched the residents smoke through the facility ' s glass door while sitting inside the facility. REC 1 pointed to a monitor on the right side of the front desk and stated, he could observe the smokers through the monitor but was not assigned to monitor the residents in the smoking area because he was assigned to do other tasks such as answer phone calls and watch the people coming in and out of the facility. REC 1 stated, REC 1 gave cigarettes to the residents whose names were on the smoking list. REC 1 stated, he was aware that Resident 3 and Resident 67 had their own cigarettes and lighters. REC 1 stated, he allowed Resident 3 and Resident 67 to keep their cigarettes and lighters because their families ' members had been supplying them with the smoking materials. During a concurrent observation and interview on 10/21/2024 at 3:43 PM with Certified Nursing Assistant (CNA) 4 in Resident 3 ' s room, there was one red lighter in the left corner of Resident 3 ' s bedside drawer. CNA 4 stated, the lighter was functional and should not be kept in Resident 3 ' s bedside drawer due to potential of fire hazard. During an interview on 10/21/2024 at 4 PM with CNA 3, CNA 3 stated no resident should keep the lighters or cigarettes. CNA 3 stated, Resident 14 and Resident 56 wanted to continuously smoke even during nonscheduled smoking time. During an interview on 10/21/2024 at 4:25 PM with the DON, the DON stated, it was the facility ' s policy not to allow residents to keep their cigarettes and lighters within their possession due to fire hazard and accidental burns. The DON stated, staff supervision during scheduled smoking time was essential to ensure the residents safely smoke their cigarettes without hurting themselves such as cigarette burn and burn from the cigarette ashes. The DON stated the facility resident ' s population included residents (unspecified) with behavior problems so staff supervision was required so that the residents would not fight or became aggressive during the smoking time. The DON stated the activity staff who was scheduled to observe and supervise in the smoking area was supposed to give out cigarettes and light the cigarettes for the residents. The DON stated, when a resident was noncompliant with the facility ' s smoking policy, she expected the previous AD (AD 1) to develop a CP and conduct an IDT meeting to address the resident ' s noncompliance. The DON stated AD 1 was no longer working for the facility since 10/10/2024 and the new hired AD (AD 2) should know how to take care of residents who were noncompliance with smoking policy. The DON stated, since AD 1 was no longer worked for the facility, no one oversaw the activity staffs to make sure the activity staffs were present during the scheduled smoking time or knew how to care for noncompliant residents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a concurrent record review and interview on 10/21/2024 at 4:30 PM with the MDS Nurse (MDSN), Resident 56 ' s CPs including the CP tilted, Smoking, dated 4/10/2024, and Resident 56 ' s IDT records since admission on 4/10/2024 were reviewed. The MDSN stated, Resident 56 was known to be noncompliant with the facility ' s smoking policy because Resident 56 kept Resident 56 ' s cigarettes and lighter at his bedside drawer. The MDSN stated, the MDSN could not find any documented evidence that a CP related to noncompliance with smoking policy in Resident 56 ' s medical record (chart). The MDSN stated there was no IDT meeting conducted for Resident 56. During a concurrent review and interview on 10/21/2024 at 4:35 PM with the MDSN, Resident 3 ' s CP tilted, Noncompliance with Smoking, dated 10/2024, indicated Resident 3 was noncompliant with the smoking schedule time, Resident 3 kept/hid his smoking cigarettes, lighter, matches and Resident 3 was at risk for injury related to smoking and non-compliance behavior. The MDSN stated, the interventions included to conduct IDT conference with Resident 3. The MDSN stated, per record, no IDT meeting was conducted with Resident 3 since 9/23/2024. During a concurrent record review and interview on 10/21/2024 at 4:40 PM with the MDSN, Resident 67 ' s CP titled, Noncompliance with Smoking, dated 8/1/2024, and Resident 67 ' s progress notes titled, Activity Participation Notes, dated 9/23/2024, were reviewed. The MDSN stated, per record, Resident 67 had been keeping the cigarettes/lighters in Resident 67 ' s possession. The MDSN stated Resident 67 did not follow the facility ' s smoking schedule and Resident 67 shared her cigarettes with other residents in the facility since 7/30/2024. The MDSN stated Resident 67 ' s CP titled, Noncompliance with Smoking, dated 8/1/2024, was not revised, and IDT meeting was not conducted when Resident 67 was found to be noncompliant with smoking during nonscheduled smoking time, and when Resident 67 refused to surrender her cigarette/lighter and supplied cigarettes to other residents on 9/23/2024. During an interview on 10/21/2024 at 4:45 PM with Payroll Staff (PS) 1 in the presence of the DON, PS 1 stated, the PS 1 was in charge of staffing scheduling. PS 1 stated, AD 1 ' s last working date was 10/9/2024. PS 1 stated, when AD 1 left, nobody was assigned to cover for the AD 1 ' s role. During an interview on 10/21/2024 at 4:51 PM with the DON, the DON stated, for residents (Resident 2, 9, 14, 18 and 136) who were noncompliant with their smoking policy, the facility supposed to develop a CP followed by an IDT meeting to go over the noncompliant issue and offer solutions, interventions, suggestions and discuss with the residents for the plan of care. The DON stated, when Resident 67 continued to be noncompliant on 9/23/2024, the AD 1 supposed to review and revise the CP to find out why Resident 67 continued to be noncompliant and to offer a different solution or adjust the interventions based on the resident ' s specific needs. During an interview on 10/21/2024 at 5:03 PM with the DON, the DON stated, the facility did not provide any supervision during scheduled and nonscheduled smoking time on 10/21/2024. The DON stated the residents (Residents 2, 3, 9, 14, 18, 56, 67 and 136) who were smoking during nonscheduled smoking time were noncompliant with the facility ' s smoking policy. The DON stated, all of the facility ' s residents were at risk for burns and fire, especially those residents that required oxygen supplement in the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 10/21/2024 at 5:22 PM with the Activity Staff (AS) 1, AS 1 stated, from 9 AM to 1 PM (nonscheduled smoking time), he was aware that some residents kept coming out to smoke with their own lighters and cigarettes. AS 1 stated, he had to let the residents smoke cigarettes as they wanted and did not know what to do. AS 1 stated, he was not at the smoking area to supervise the residents who smoked from 1PM to 2PM on 10/21/2024 because he was busy [TRUNCATED]

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 28), was administered with the correct feeding formula (nutritional formula) delivered via gastrointestinal tube (GT- a tube surgically inserted into the stomach to deliver liquids and medications) as ordered by the physician. This failure had a potential to result in Resident 28's weight loss, intolerance (not able to absorb formula effectively) to GT feeding formula, such as having increased GT residual, vomiting, diarrhea, and stomach pain/discomfort. Findings: During a review of Resident 28's Admission Record, indicated Resident 28 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia [the loss of cognitive functioning (thinking, remembering, and reasoning) to such an extent that it interferes with a person's daily life and activities], gastrostomy (a surgical procedure used to insert a tube, often referred to as a G-tube, through the abdomen and into the stomach), protein-calories malnutrition (inadequate intake of food as a source of protein, calories, and other essential nutrients), and dysphagia (difficulty swallowing). During a review of Resident 28's History and Physical (H&P), dated 4/25/2024, indicated Resident 28 did not have the capacity to understand and make decisions. During a review of Resident 28's Nutrition Care Plan, and Resident Care Plan: G-tube Feeding, dated 4/11/2024, indicated Resident 28 was at risk for altered nutrition/hydration related to dementia, malnutrition (poor nutrition or food intake) and the intervention was to give GT feeding as ordered. During a review of Resident 28's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/22/2024, indicated Resident 28 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in activity of daily livings including eating, and had active diagnosis of or at risk of malnutrition. During a review of Resident 28's Order Summary Report, indicated on 9/18/2024, Resident 28 had a physician order to administer Peptamen [NAME] PHGG (a type of tube feeding formula) and/or Vital AF 1.2 (a type of tube feeding formula) at the rate of 80 ml (unit of volume) per hour for 20 hours. During a review of Resident 28's Nutrition/Dietary Note, dated 9/10/2024, indicated Resident 28 had recommendation for Peptamen [NAME] PHGG or Vital AF 1.2 at the rate of 80 ml per hour for 20 hours with the goal of weight gain. During an observation on 10/21/2024 at 12:17 PM in Resident 28's room, a bag of Peptamen AF tube (not the Peptamen [NAME] PHGG as the physician ordered) feeding was observed running at 80 ml/hr by a flexible tube that connected to Resident 28's GT on the left abdomen area. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/23/2024 at 8:47 AM with the Registered Dietician (RD), the RD stated, there were different type of tube feeding formula depending on the resident's diagnosis and how much they could tolerate. The RD stated, Peptamen [NAME] PHGG and Peptamen AF were not the same formula. The RD stated, she recommended Peptamen [NAME] PHGG because it was gentler to the resident's stomach and had less allergens (chemicals that causes allergic reaction). The RD stated, in case they had to use an alternative formula, the nurses would need to let her know so she could adjust the rate accordingly. The RD stated, if the incorrect tube feeding formula was given for a long time, the resident would not be able to tolerate it, such as having high residual, vomiting, and diarrhea. During a concurrent observation and interview on 10/23/2024 at 9:33 AM with Registered Nurse (RN) 2 in Resident 28's room, a bag of Peptamen AF tube feeding was observed running at 80 ml/hr by a flexible tube that connected to Resident 28's left abdomen area. RN 2 stated, they had been using Peptamen AF to feed Resident 28 via GT. RN 2 stated, she thought Peptamen [NAME] PHGG and Peptamen AF are the same formula. During an interview on 10/23/2024 at 10 AM with the Director of Nurses (DON), the DON stated, Peptamen [NAME] PHGG and Peptamen AF were two different tube feeding formulas. The DON stated, when an alternative formula was used, the nurse must let the doctor know to have an order for the new formula to be used. The DON stated, incorrect formula could result in Resident 28's intolerance to GT feeding formula and potentially resulted in weight loss. During a review of the facility's policy and procedure (P&P) titled, Enteral Nutrition, dated November 2018, indicated enteral nutrition is ordered by the provider based on the recommendations of the dietitian, complete orders for entera nutrition included the enteral nutrition product, potential benefits of using a feeding tube included addressing malnutrition and dehydration.

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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** 50012 Based on observation, interview and record review, the facility failed to ensure one of three sample residents (Resident 55) was provided respiratory care was consistent with professional standards of practice and facility's policy and procedure for by failing to ensure Resident 55's nebulizer mask (changes medication from a liquid to a mist so you can inhale it into your lungs) was kept in a plastic bag when not in use. The deficient practice had the potential to spread bacteria and infection to the residents and resulted in contamination of Residents 55's oxygen equipment and can place the resident at risk for infection. Findings: During a review of Resident 55's Admission Record (Face Sheet), dated 7/25/2023, the face sheet indicated the facility admitted Resident 55 on 7/25/2023, and readmitted on [DATE] with diagnoses including disorder of the lung and generalized anxiety disorder. During a review of Resident 55's Minimum Data Set (MDS-a federally mandated resident assessment tool.), dated 9/7/2024, indicated the cognitive (the ability to think and process information) skills for daily decisions making was intact, and required limited assistance of one-person physical assist for activities of daily living. During a review of Resident 55's History and Physical (H&P), dated 8/1/2024, indicated, Resident 55 had the mental capacity to make medical decisions. During a review of Resident 55's Order Summary Report dated 10/01/2024, indicated a physician order for Ipratropium-Albuterol Nebu Solution (a medication that opens the medium and large airways in the lungs) 0. 5-2.5 (3) milligram (mg) /3 milliliters (ml) 3 ml inhale orally every 4 hours as needed for Shortness of Breath (SOB) give 1 Nebule (a small cloud) via a hand-held nebulizer (HHN) nebulizer with a start date of 8/1/2024. During an observation on 10/22/2024 at 11:20 AM, in Resident 55 room, Resident 55 was observed lying on the bed. Resident 55's nebulizer mask was observed placed on top of Resident 55's bedside dresser. During an interview on 10/24/2024 at 3:05 PM with the Infection Prevention Nurse (IP), the IP stated Resident 55's nebulizer mask should be kept in bag when not in use to prevent from getting any contamination. During a review of the facility P&P titled, Departmental (Respiratory Therapy)- Prevention of infection, dated 11/2011, indicated Infection Control Considerations Related to Medication Nebulizers/Continuous Agents: 1. Obtain equipment (i.e., administration set-up, plastic bag, gauze sponges). (continued on next page)

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	056111	A. Building B. Wing	10/24/2024

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Griffith Park Healthcare Center	201 Allen Ave. Glendale, CA 91201

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Wash hands. 3. After completion of the therapy: a. Remove the nebulizer container; b. Rinse the container with fresh tap water; and c. Dry on a clean paper towel or gauze sponge. 4. Reconnect to the administration: set-up when air dried. 5. Take care not to contaminate internal nebulizer tubes. 6. Wipe the mouthpiece with damp paper towel or gauze sponge. 7. Store the circuit (the tubing that connects a nebulizer to an air pump, called a compressor, and to a mouthpiece or mask) in plastic bag, marked with date and resident's name, between uses. 8. Wash hands. 9. Discard the administration: set up every seven (7) days.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 47467 Based on observation, interview, and record review, the facility failed to ensure that the facility had sufficient staffing to monitor and supervise 8 out of 23 sampled residents (Resident 2, 3, 9, 14, 18, 56, 67 and 136) while smoking during the scheduled and nonscheduled smoking time in the patio and monitor for residents that are at risk of elopement (leaving the facility without permission) from 1-2 PM on 10/21/2024. These failures could result in the residents to be at risk for accidental burn, fire and accidents that could result in major injuries and death. Findings: During an observation on 10/21/2024 at 11:10 AM (nonscheduled smoking time) in the smoking area, seven (7) unidentified residents were smoking in the patio without a staff present supervising the residents. During an observation on 10/21/2024 from 1PM to 2PM (scheduled smoking time) in the facility's designated smoking area, a total of 8 residents (Resident 2, 3, 9, 14, 18, 56, 67 and 136) were smoking without any staff supervision. During an interview on 10/21/2024 at 5:22 PM with the Activity Staff (AS) 1, AS 1 stated, during the scheduled smoking time between 1-2 PM, he was not able to supervise the smoking area while the residents were smoking because he was busy doing activities with the residents inside the facility. AS 1 stated, the facility had been having problems with short staffing, in which for a few times he had to concurrently observe the smoking area and the other areas in the facility to monitor the resident at risk of elopement. During an interview on 10/22/2024 at 12:10 PM with the AS 2, the AS 2 stated, he was not at the smoking area from 1-2 PM on 10/21/2024 because he was assigned to monitor the facility's entrance and the street to ensure residents who were at risk for elopement did not leave the facility. The AS 2 stated, sometimes he watched the smoking area and the street at the same time. During an interview on 10/22/2024 at 3:30 PM with the MR, the MR stated, besides doing his task as a medical record personnel, he was also assigned to monitor and watch the outside facility for residents on elopement risk from 10/1/2024 to 10/4/2024, on 10/8/2024, 10/9/2024, 10/14/2024, and 10/15/2024 by the previous Activity Director (AD) 1 due to the facility's short staffing. During an interview on 10/22/2024 at 3:50 PM with Licensed Vocational Nurse (LVN) 5, LVN 5 stated, he usually clocked out of his timecard when he ended his working day or when he left the facility. LVN 5 stated, the facility had been having issue with short staffing, he had been asked by the AD 1 to stay over on 10/9/2024 and 10/17/2024 to watch the outside facility for residents on elopement risk. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/24/2024 at 11 AM with the Director of Nurses (DON), the DON stated, each designated area for smoking and elopement was supposed to be assigned to one activity staff per area. The DON stated, one staff should not watch both areas at the same time because there would be no supervision provided to the smoking area with residents smoking if the staff was watching on the street for residents at risk for elopement, and there would be no staff to monitor the resident at risk for elopement if the staff was supervising the residents in the smoking area, The DON stated, the lack of sufficient staff contributed to the lack of staff supervision provided to the residents while smoking scheduled/nonscheduled smoking times on 10/21/2024. During a review of the facility ' s Policy and Procedure (P&P) titled, Staffing, Sufficient and Competent Nursing, dated, indicated the facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. Other resident services (e.g., administrative, food and nutrition services, specialized rehabilitation services, activities/recreational, social, therapy, environmental, etc.) are staffed to ensure that resident needs are met.

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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 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** 46779 Based on observation, interview and record review, the facility failed to accurately and safely provide pharmaceutical services, in accordance with the facility ' s policy and procedure (P&P) titled Controlled Substances and Discarding and Destroying Medications, by failing to: 1.Properly discard and destroy the remaining Morphine Sulfate (MS, a controlled medication [a drug whose manufacture, possession, or use is regulated by a government] is used to treat moderate to severe pain) for Resident 72. 2. Document the MS administered to Resident 72 on her Control Drug Record on 10/10/2024 in accordance with the facility ' s P&P. 3. Document the correct instruction and the correct volume of the MS to start on Resident 72 ' s Control Drug Record. 4. Maintain a record of the receipts of Resident 72 ' s MS that was delivered by the hospice pharmacy. 5. Ensure the nurses to sign on the facility ' s Narcotic Medications Surveillance when they completed the narcotic count. These deficient practices had placed Resident 72 at risk for medication errors, which could lead to adverse reactions (any unexpected or dangerous reaction to a drug) for Resident 72. In addition, the deficient practices could lead to narcotic loss, misuse and undetected diversion (illegal distribution or abuse of prescription drugs or their use for unintended purposes) of controlled medications. Findings: During a review of Resident 72 ' s Admission Record indicated the facility admitted Resident 72 on 6/30/2023 with diagnoses that included dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) and malnutrition (lack of sufficient nutrients in the body). During a review of Resident 72 ' s Order Summary Report, dated 9/30/2024, indicated the physician ordered to administer MS Oral Solution 20 milligram (mg, a unit of measurement)/milliliter (ml, a unit of measurement) 0.25 ml orally in the morning for pain, starting on 7/31/2024. During a review of Resident 72's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 10/5/2024, indicated Resident 72 had severe cognitive (ability to think and reasonably) impairment. The MDS indicated Resident 72 required supervision or touching assistance with eating, oral hygiene, and personal hygiene, and partial/moderate assistance with toileting hygiene, shower/bathe self, and chair/bed-to-chair transfer. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. During a concurrent observation and interview on 10/23/2024 at 11:40 AM, Registered Nurse (RN) 2 and Licensed Vocational Nurse (LVN) 3 were observed conducting narcotic count (a process that two licensed nurses count the controlled medications stored in the narcotic drawer to verify the actual number of controlled medications were matching the records) in the narcotics drawer of Medication Cart 2 RN 2 and LVN 3 upon completing the count, RN 2 and LVN 3 were not observed counting Resident 72 ' s MS solution in the vial in the narcotics drawer of Medication Cart 2. RN 2 stated she did not notice Resident 72 ' s MS solution in the narcotics drawer. During the observation, LVN 3 stated she did not see a Controlled Drug Record (a document used to document and track the administration of controlled medication) for MS for Resident 72 in the Active Narcotics Binder (a binder holds the Controlled Drug Records for the controlled medications that residents currently using) during the count, so she did not count the MS solution. During a concurrent interview and record review on 10/23/2024 at 11:45 AM with LVN 3, Resident 72 ' s Controlled Drug Record for MS, dated 7/31/2024 to 10/9/2024, was reviewed. LVN 3 stated the Controlled Drug Record for MS was filed in the Completed Narcotics Binder (a binder holds the Controlled Drug Records of the controlled medications that residents had completed) and she could not find the current Controlled Drug Records of MS for Resident 72 in the active facility records. LVN 3 stated Resident 72 ' s Controlled Drug Record for MS indicated 15 ml of MS was remaining. LVN 3 stated the physician discontinued the MS on 10/10/2024. LVN 3 stated the nurse should turn in the remaining MS vial and the Controlled Drug Record to the DON for destruction on 10/10/2024. LVN 3 stated the nurse should not have left the remaining MS vial in the narcotics drawer in the medication cart up until now and should not have filed the Controlled Drug Record for MS in the Completed Narcotics Binder. During an interview on 10/23/2024 at 12:04 PM with RN 2, RN 2 stated she did not know why Resident 72 ' s remaining MS vial, that was discontinued on 10/10/2024, remained in the narcotics drawer of Medication Cart 2. RN 2 stated if MS was discontinued and there was remaining MS in the vial, the nurse who received the medication order to be discontinued should surrender the remaining MS in the vial and the Controlled Drug Record for MS to the DON right away for proper destruction to prevent potential diversion. During an interview and record review on 10/23/2024 at 12:37 PM with the Director of Nurses (DON), the Narcotics Destruction Binder was reviewed. The DON stated there was no destruction of MS for Resident 72 in the past three months and no staff had turned in Resident 72 ' s MS for destruction. The DON stated the nurse who received the discontinued order should bring the remaining MS and the Controlled Drug Record to her immediately after receiving the order for destruction, so that it could be destroyed properly to prevent potential diversion of the controlled medication. During an observation on 10/24/2024 at 11:56 AM, the DON and RN 1 destroyed 5.8 ml of MS from the MS bottle, dated 9/4/2024. The DON documented the destruction on the Narcotic Destruction Binder. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/24/2024 at 12:00 PM with the DON, Resident 72 ' s Controlled Drug Record for MS, dated 7/31/2024 to 10/9/2024 was reviewed. The DON stated according to the record, the remaining MS should had been 15 ml for destruction, but she and RN 1 only destroyed 5.8 ml of MS. The DON stated she was responsible for overseeing the controlled medications, but she solely relied on the licensed nurses to bring the controlled medication for destruction to her and she trusted that her staff would follow the policy and procedures. The DON stated for hospice (a type of care that provides physical comfort and emotional, social and spiritual support for people nearing the end of life) residents, such as Resident 72, if the nurses did not bring the controlled medication for destruction to her, she would not know which and how much of a controlled medication needed to be destroyed because she did not keep a record for what controlled medications and how much of them being delivered by the hospice pharmacy to the facility. 2. During a review of Resident 72 ' s Medication Administration Record (MAR), dated 10/1/2024 to 10/10/31/2024, indicated Resident 72 received MS 20mg/ml 0.25 ml orally on 10/10/2024. During a concurrent interview and record review on 10/23/2024 at 12:20 PM with RN 2, Resident 72 ' s Control Drug Record for MS, dated 7/31/2024 to 10/9/2024, was reviewed. RN 2 stated LVN 4 administered MS 20 mg/ml 0.25 ml and documented it on the MAR on 10/10/2024, without documenting in the Control Drug Record on 10/10/2024. RN 2 stated LVN 4 should document the amount of MS that she had took out to administer to Resident 72 on 10/10/2024 to ensure the count for MS was correct. During an interview on 10/23/2024 at 12:35 PM with the DON, the DON stated when the nurse removed a controlled medication to administer to a resident, the nurse must document on the Controlled Drug Record so that they could keep track on the count of the controlled medications and prevent medication errors and diversion. During a telephone interview on 10/23/2024 at 1:28 PM with LVN 4, LVN 4 stated she did not remember if she administered MS to Resident 72 on 10/10/2024. LVN 4 stated according to the facility ' s P&P the nurses should document how much MS was taken out from the narcotics drawer on the Controlled Drug Record and how much MS was administered to the resident on the MAR to keep track of the count on controlled medications. 3. During a review of Resident 72 ' s Controlled Drug Record for MS, dated 7/31/2024 to 10/9/2024, indicated to administer Morphine Sulfate 100mg/5ml Conc. Give 0.25 under tongue Q (every) 4 PRN (as needed) for severe pain. The Controlled Drug Record indicated the receiving MS vial was 30 ml. During a review of Resident 72 ' s MS Pharmacy Delivery Receipt, dated 7/29/2024, indicated MS 100mg/5ml in a quantity of 15 was delivered on 7/29/2024 at 9:09 PM. During a review of Resident 72 ' s MS Pharmacy Delivery Receipt, dated 8/22/2024, indicated MS 100mg/5ml in a quantity of 3.75 was delivered on 8/22/2024 at 12:33 PM. During a review of Resident 72 ' s MS Pharmacy Delivery Receipt, dated 9/5/2024, indicated MS 100mg/5ml in a quantity of 3.75 was delivered on 9/5/2024 at 2:10 PM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/23/2024 at 12:36 PM with RN 1, RN 1 stated Resident 72 was on MS 20mg/ml 0. 25ml daily since 7/31/2024 and the physician did not order MS every four hours as needed. RN 1 stated the instruction for the use of MS on Resident 72 ' s Controlled Drug Record was incorrect. RN 1 stated the nurse who received the delivery of MS should verify the instruction on the Controlled Drug Record by checking the physician order. RN 1 stated if there was a discrepancy on the record, the nurse must clarify the order and correct the Controlled Drug Record. During a telephone interview on 10/24/2024 at 12:17 PM with Pharmacist 1, Pharmacist 1 stated the pharmacy delivered MS 100mg/5ml in a quantity of 15 ml to the facility on [DATE], 3.75 ml on 8/22/2024, and 3.75 ml on 9/5/2024. During an interview on 10/24/2024 at 4:40 PM with the DON, the DON stated the received volume listed in Resident 72 ' s Controlled Drug Record was incorrect. The DON stated the nurse who received the MS should have written 15 ml instead of 30 ml on the Controlled Drug Record. The DON stated the pharmacy delivered the MS one bottle at a time for three times on 7/29/2024, 8/22/2024 and 9/5/20204, and the nurse should create three separate Controlled Drug Records for the MS they received on 7/29/2024, 8/22/2024 and 9/5/2024. The nurse should check the physician ' s order and the MS vial to make sure the instruction and the receiving amount of the medication were correct to prevent medication errors and diversion of controlled medications. 4. During a concurrent interview and record review on 10/24/2024 at 10:27 AM with the Infection Preventionist (IP), Resident 72 ' s MS Pharmacy Delivery Receipt, dated 9/5/2024, was reviewed. The IP stated LVN 4 was busy, and he helped LVN 4 to sign for the delivery of Resident 72 ' s MS on 9/5/2024. The IP stated he handed the MS over to LVN 4 after he received the MS from the pharmacy. The IP stated he did not know what LVN 4 do with the new bottle of MS. During an interview on 10/24/2024 at 11:05 AM with the DON, the DON stated Resident 72 was under hospice care and her medications were provided by a hospice pharmacy. The DON stated the facility does not keep the receipts of the medications delivered from the hospice pharmacy for Resident 72. The DON stated so she does not know what controlled medications was facility received from the pharmacy. The DON stated without the receipt information, she could not accurately reconcile (a process of comparing a patient ' s medication orders to all of the medications that the patient has been taking) what quantity of MS was administered or destroyed to Resident 72, which could lead to undetected diversion of the controlled medications. During a telephone interview on 10/24/2024 at 4:14 PM with Pharmacist 2, Pharmacist 2 stated he could review and monitor the controlled medications that delivered by the facility pharmacy because he had records of them, but it was hard to follow up the controlled medications that were delivered by the hospice pharmacy because he did not have records of those deliveries. Pharmacist 2 stated he reviewed the count sheets (Controlled Drug Record) of the controlled medications when they were destroyed with the DON, but he did not know what controlled medication and its quantity was delivered to the facility to start by the hospice pharmacy. 5. During a record review of Narcotic Medications Surveillance for Station 2, dated 8/2024, 9/2024, and 10/2024, indicated no signature for the narcotic count that was performed for the following dates and work shifts: Date Time Nurse(s) (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/5/2024 11 PM Leaving 8/10/2024 11 PM Leaving 8/12/2024 11 PM Oncoming 8/13/2024 3 PM Leaving 8/18/2024 3 PM Oncoming 8/19/2024 3 PM Oncoming 8/19/2024 11 PM Oncoming & Leaving 8/20/2024 3 PM Oncoming 8/20/2024 11 PM Leaving 8/21/2024 11 PM Oncoming 8/22/2024 7 AM Leaving 8/24/2024 11 PM Leaving 8/25/2024 11 PM Oncoming 8/26/2024 7 AM Leaving 8/28/2024 11 PM Oncoming 8/29/2024 7 AM Leaving 8/30/2024 11 PM Oncoming 8/31/2024 7 AM Leaving 8/31/2024 3 PM Oncoming 9/4/2024 11 PM Leaving 9/6/2024 11 PM Oncoming 9/7/2024 3 PM Leaving 9/8/2024 7 PM Leaving 9/9/2024 3 PM Oncoming (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/9/2024 11 PM Leaving 9/11/2024 3 PM Oncoming 9/11/2024 11 PM Leaving 9/13/2024 3 PM Oncoming 9/13/2024 11 PM Leaving 9/16/2024 11 PM Leaving 9/17/2024 11 PM Leaving 9/18/2024 11 PM Leaving 9/21/2024 3 PM Oncoming 9/21/2024 11 PM Leaving 9/22/2024 3 PM Oncoming 9/23/2024 11 PM Leaving 9/24/2024 11 PM Leaving 10/1/2024 11 PM Leaving 10/2/2024 3 PM Oncoming 10/2/2024 11 PM Leaving 10/4/2024 3 PM Oncoming 10/4/2024 11 PM Leaving 10/5/2024 3 PM Oncoming 10/5/2024 11 PM Leaving 10/6/2024 3 PM Oncoming 10/6/2024 11 PM Leaving 10/8/2024 7 AM Oncoming 10/14/2024 11 PM Oncoming & Leaving (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/15/2024 7 AM, 11 PM Leaving 10/16/2024 3 PM Oncoming 10/16/2024 11 PM Leaving 10/21/2024 11 PM Oncoming & Leaving 10/22/2024 7 AM Leaving 10/23/2024 11 PM Leaving During a concurrent interview and record review on 10/24/2024 at 1:23 PM with LVN 1, the Narcotic Medications Surveillance for Station 2, dated 10/2024, were reviewed. LVN 1 stated the in-coming nurses, and the out-going nurses should conduct narcotic count at the end of each shift together and both nurses should sign on Narcotic Medication Surveillance to make sure the count for the controlled medications were correct. LVN 1 stated there were multiple unsigned sections on the Narcotic Medication Surveillance log indicating the nurses did not reconcile the medications together. LVN 1 stated if there was no documentation that means it was not done. During a concurrent interview on 10/24/2024 at 4:42 PM, the DON stated the nurses should sign on the Narcotic Medication Surveillance when they completed the narcotic count at the end of each shift. The DON stated if there was no documented or signatures, the narcotic count was not done for those shifts. The DON stated she did not oversee and review the Narcotic Medication Surveillance logs because she trusted her staff nurses. The DON stated she should have audited the Narcotic Medication Surveillance logs to ensure the nurses conducted the narcotic count each shift to prevent undetected diversion of the controlled medications. During a review of the facility ' s policy and procedure (P&P) titled, Controlled Substances, dated 11/2022, indicted controlled substances are counted upon delivery. The P&P indicated the nurse receiving the medication and the person delivering the medication must count and sign the designated controlled substance record. The P&P indicated If the count is correct, an individual resident-controlled substance record is made for each resident who will be receiving a controlled substance. Do not enter more than one prescription per page. This record contains: .Quantity received; number on hand; . time of administration, and Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loos/diversion and detection/follow-up. The P&P also indicated Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count. During a review of the facility ' s P&P titled, Discarding and Destroying Medications, dated 11/2022, indicated Disposal of Controlled substances must take place immediately (no longer than three days) after discontinuation of use by the resident.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46779 Based on observation, interview, and record review, the facility failed to implement the facility's policy and procedure by ensuring to store all drugs and biologicals in a safe, secure, and orderly manner, under proper temperature, light, and humidity controls and controlled medications are stored in separately locked, permanently affixed compartments for four of five sampled residents (Residents 3, 66, 69 and 76). The facility failed to: 1. Store Glargine (a medication to treat diabetes [a group of disease that result in too much sugar in the blood]) Pen for Residents 3, 69, 76. 2. Store Lorazepam (a controlled medication to treat anxiety) oral (given by mouth) concentrate in a sanitary environment inside the medication refrigerator at the Medication room [ROOM NUMBER] for Resident 66. 3. Store Lorazepam oral concentrate within the required temperature range between 36 Fahrenheit degrees (F, a unit of measurement of temperature) and 46 F in the medication refrigerator in the Medication room [ROOM NUMBER]. 4. Ensure Lorazepam oral concentrate was separately locked in permanently affixed compartment for Resident 66's. These deficient practices had the potential to result in deterioration in the integrity of medication and its potency and potential for the residents to receive ineffective drug dosages. In addition, the deficient practice had the potential to result in undetected diversion (illegal distribution or abuse of prescription drugs or their use for unintended purposes) or loss of controlled medication. Findings: 1a. During a review of Resident 3's Admission Record (AR) indicated the facility originally admitted Resident 3 on 10/10/2017 and readmitted on [DATE] with diagnoses that included diabetes (a condition of having high blood sugar) and hyperlipidemia (a condition in which there are high levels of fat in the blood). During a review of Resident 3's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/6/2024, indicated Resident 3 had no memory impairment and cognition (ability to think and reasonably) impairment. During a review of Resident 3's Order Summary Report (OSR), dated 9/30/2024, indicated the physician ordered to administer Insulin Glargine 20 unit subcutaneously (under the skin) every 12 hours, starting on 6/3/2024. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1b. During a review of Resident 69 's AR, indicated the facility originally admitted Resident 69 on 4/10/2023 and readmitted on [DATE] with diagnoses that included diabetes and hyperlipidemia. During a review of Resident 69's MDS, dated [DATE], indicated Resident 69 had moderately impaired memory and cognitive impairment. During a review of Resident 69's OSR, dated 9/30/2024, indicated the physician ordered to administer Insulin Glargine 100 unit/milliliter (ml, a unit of measurement) six ml subcutaneously at bedtime, starting on 6/3/2024. 1c. During a review of Resident 76's AR, indicated the facility originally admitted Resident 76 on 2/26/2024 and readmitted on [DATE] with diagnoses that included diabetes and cellulitis (a deep infection of the skin caused by bacteria) of right lower limb. During a review of Resident 76's MDS, dated [DATE], indicated Resident 76 had moderate memory and cognitive (ability to think and reasonably) impairment. During a review of Resident 76's OSR, dated 10/1/2024, indicated the physician ordered to administer Insulin Glargine 100 unit/milliliter (ml, a unit of measurement) six ml subcutaneously at bedtime, starting on 10/2/2024. 2. During a review of Resident 66's AR, indicated the facility admitted Resident 66 on 7/1/2022 with diagnoses that included anxiety disorder (a mental health condition that involves persistent and excessive worry that interferes with daily activities) and dementia (a chronic condition that causes a decline in mental abilities, such as thinking, remembering, and reasoning, that interferes with daily life). During a review of Resident 66's MDS, dated [DATE], indicated Resident 66 had severely impaired cognitive skills for daily decision making. During a review of Resident 66's OSR, dated 9/30/2024, indicated the physician ordered to administer Lorazepam Concentrate 2 milligram (mg, a unit of measurement)/ milliliter (ml, a unit of measurement) 0.25 ml sublingually every 12 hours as needed for anxiety manifested by physical restlessness as evidenced by thrashing back and forth in the bed, starting on 6/3/2024. During a concurrent observation and interview on 10/22/2024 at 1:36 PM, with Licensed Vocational Nurse (LVN) 3, inside the Medication room [ROOM NUMBER], a single door mini refrigerator with freezer compartment with water dripping down from the freezer to the first shelf of the refrigerator that had accumulated pool of water and also dripped into a blue bin containing Insulin Glargine pens labeled with Residents 3, 69 and 76's names, stored in a partially sealed Ziploc bags with water that dripped down from the freezer. In addition, a vial of Lorazepam oral concentrate and an empty syringe were inside a box stored on the first shelf of the refrigerator door. The Lorazepam box, the syringe and the plastic syringe cover were wet. LVN 3 stated the ice from the freezer compartment melted inside the refrigerator and caused water to go into the other parts of the refrigerator where the medications were stored. LVN 3 stated she did not know the ice melted until the surveyor informed her. LVN 3 stated it was important to store medication properly to prevent contamination and ensure the efficacy of medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/22/2024 at 1:43 PM, with Registered Nurse (RN) 1, RN 1 stated the medication refrigerator should be checked every shift to make sure it was dry and clean to protect the medications. During an interview on 10/22/2024 at 1:46 PM, with the LVN 3, LVN 3 stated she checked the refrigerator this morning, but she did not check if there was water in the refrigerator and did not check if the ice was melting from the freezer compartment in the morning. LVN 3 stated she did not know for how long the refrigerator was not working properly. During an interview on 10/22/2024 at 2:17 PM, with the Maintenance Supervisor (MS), the MS stated the nurses was responsible to check if the ice was melting from the freezer compartment inside the medication refrigerator and he did not know about the ice was melting in the medication refrigerator at Medication room [ROOM NUMBER] until the nurses informed him just now. The MS stated he found the temperature regulator inside the refrigerator was pointing at number five, which was the wrong setting and resulting the ice from the freezer compartment started to melt. The MS stated he did not know who change the setting. During an interview on 10/24/2024 at 4:47 PM, with the Director of Nursing (DON), the DON stated the inside of the refrigerator where medications were stored should be wet to prevent damage of the medication and contamination. 3. During a concurrent observation and interview on 10/24/2024 at 7:50 AM, with the DON, in the Medication room [ROOM NUMBER], the door of the refrigerator where the medication was stored was open and the thermometer and inside the refrigerator read 52 F. A vial of Resident 66's Lorazepam oral concentrate was stored inside the refrigerator. The DON stated she did not know when and who opened the refrigerator and did not close it. The DON stated the door of the medication refrigerator should be closed to maintain at the correct temperature between 36 F and 42 F. During a concurrent interview and record review on 10/24/2024 at 7:52 AM, with the DON, Refrigerator's Temperature for Station 1, dated 10/2024, was reviewed. The DON stated the temperature of the medication refrigerator was out of range and should be kept between 36 F and 42 F to ensure the potency of the medications. During a concurrent interview and record review on 10/24/2024 at 7:54 AM, with the DON, the Label and Instruction on Resident 66's Lorazepam Oral Concentrate box was reviewed which indicated to keep refrigerate between 36 F and 46 F. The DON stated the temperature of the medication refrigerator was out of range and Resident 66's Lorazepam was stored at the wrong temperature, as the result, Resident 66's Lorazepam might not be effective to control her anxiety and should not be administered to Resident 66. 4. During a concurrent observation and interview on 10/24/2024 at 7:57 AM, with the DON, in Medication room [ROOM NUMBER], Resident 66's Lorazepam Oral Concentrate was inside the medication refrigerator, which was not locked. The DON stated Resident 66's Lorazepam Oral Concentrate should be stored and locked separately from other medications to prevent undetected of controlled medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and Procedure (P&P) titled, Storage of Medications, dated 4/2019, indicated the facility stores all drugs and biologicals in a safe, secure, and orderly manner, under proper temperature, light, and humidity controls. The P&P indicated controlled medications are stored in separately locked, permanently affixed compartments.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50012 Based on observation, interview and record review, the facility failed to provide one out of 23 sampled residents (Residents 62) with meals that accommodated the resident's food preferences. Residents 62 received tomato products and milk with her meals, despite her dislikes for tomato products and allergy to milk. This deficient practice had the potential to result in decreased meal intake and can lead to weight loss and malnutrition. Findings: During a review of Resident 62's Admission Record, indicated Resident 62 was admitted to the facility on [DATE] with diagnoses that included Moderate Protein-Calorie Malnutrition (lack of proper nutrition, caused by not having enough to eat, not eating enough of the right things, or being unable to use the food that one does eat) and Gastro-esophageal reflux disease (GERD-is a chronic condition that occurs when stomach contents flow back up into the esophagus). During a review of Resident 62's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 10/14/2024, indicated Resident 62 had moderate impairment of cognitive (the ability to think and process information) skills for daily decisions making. During an interview with Resident 62 on 10/21/2024 at 10:52 AM, the resident stated, Food is a problem. Resident 62 stated her food preferences of not to be served milk products were not considered and the facility continued to serve her milk products which she was allergic to, and she was still being served tomato products even though she told dietary staff that she does not like tomatoes. Resident 62 stated I have GERD and tomatoes triggers it. Resident 62 stated, her food preference Even says on my menu card. During a dining observation on 10/21/2024 at 12:35 PM, in the Resident 62 ' s room, Resident 62 ' s lunch tray was served on the table in front of her. Resident 62's meal included spaghetti, ground beef, zucchini, and chocolate ice cream. The tray meal card read: no added salt (NAS), consistent/controlled carbohydrates (CCHO) diet, mechanical soft texture. Resident 62's meal card indicated her food dislikes are Tomato Products, Milk products, milk, and spinach. During an observation with Registered Nurse 1 (RN 1) on 10/21/2024 at 12:39 PM, in Resident 62's room, RN 1 confirmed that the resident received tomato products even though it is indicated as Dislike Tomatoes in the meal card. RN 1 stated Resident 62 should not have been served tomato sauce and alternative should have been given to the resident. RN 1 removed the tray and took it back to the kitchen and requested an alternative meal for the resident. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Dietary Supervisor (DS) on 10/22/2024 at 9:23 AM, the DS stated he goes to each individual resident and asks them about their preferences. The DS also stated he revises the menus to take in resident suggestions and preferences. When asked about who was responsible for checking diet cards and comparing it to the trays, the DS stated that there are three checks. Before the tray leaves the kitchen, the tray line staff checks the menu cards with the tray. The DS stated he, himself, does a final check before the trays go out or if he is not available the Dietary supervisor assistant (DSA) does the second check. The third and final check is the licensed nurse who helps pass out the trays to the residents. During a review of the facility policy and procedure titled Food substitutions during tray line and alternative for food item recorded on the tray card indicated, the cook will provide a food substitute at each meal for a food item that a resident may dislike, which has been noted on their tray card.

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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. 50012 Based on observation, interview, and record review, the facility failed to ensure the food were stored prepared and distributed of food under sanitary conditions to all the residents in the facility in accordance with the facility ' s policy and procedure by failing to: 1. Monitoring and documenting Sanitization Sink Solution Log. 2. Monitoring and documenting Cold Storage temperature Log. 3. Monitoring and documenting Sanitization Solution Log. These deficient practices placed the residents at risk for foodborne illnesses (refers to illness caused by the ingestion of contaminated food or beverages). Findings: 1. During a concurrent observation and interview on 10/1/2024 at 9:33 AM during an initial Kitchen tour in the presence of Dietary Aid (DA), when asked about the three-compartment sink washing procedure, the DA stated he first removes all food particles by either soaking, scraping, or rinsing. The first compartment is for washing dishes, the second is for rinsing with hot water, and the third is for sanitizing. DA tested the water with the test strip, and it read 200ppm. The DA would then log the results in the sink sanitation log. Observed the water to be pink and clear. During a concurrent interview and record review on 10/21/2024 at 9:33 AM with the Dietary Supervisor Assistant (DSA), the review of the Sanitizing Sink solution log was reviewed. DSA stated the Sanitizing Sink solution log was missing entries for the PM shift (afternoon) on 10/4/2024 through 10/8/2024 and from 10/11/2024 through 10/15/2024 and 10/18/2024 through 10/21/2024. According to DSA, staff members should fill out the sanitizing sink log twice during each shift to verify that the sanitization solution is working effectively. DSA stated that if it is not recorded, it is unknown if the water was tested for the appropriate sanitizing range for Sani-Tech which is 200ppm- 400ppm (parts per million or ppm means out of a million). During a review of the facility's policy and procedure (P&P) titled, 3-Compartment procedure for manual dishwashing, Test the concentration with the appropriate test strips, which is dipped in the sanitizer solution 10 seconds before reading and record on the log. 2. During a concurrent initial kitchen observation and interview in the presence of the Dietary Supervisor Assistant (DSA), on 10/21/2024 at 9:40 AM, the DSA stated the cook comes in and checks the refrigerator and freezer temperatures and logs them in the log. Keeping track of the temperature is essential because if it is not working correctly, the food can go wrong, becoming a real problem. The temperature must be logged in the fridge temperature logs when they check it. Temperatures are checked twice a day. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 10/21/2024 at 9:40 AM with the DSA, the Cold Storage Temperature Log review for October 2024 had missing entries for the PM shift on 10/25/2024. During a review of the facility's policy and procedure (P&P) titled, Procedure for refrigerated storage, indicated, A temperature will be logged in twice daily by a designated employee upon opening of the kitchen and upon closing the kitchen. 3. During a concurrent interview and record review on 10/21/2024 at 9:45 AM with the DSA, the Sanitizer Solution Log for October 2024. The form indicated the use of Quaternary sanitizing solution (sanitizing solution): Dip a quaternary strip into the solution to be tested for 1-2 seconds; compare the strip to the color chart; it should read between 200-400ppm. The DSA stated there was no record to indicate that the sanitization solution in the red bucket from 12 PM to 6 PM on 10/1/2024 through 10/19/2024 was tested for the concentration of the solution. DSA stated staff is supposed to fill out the log every two hours after testing the water for 1-2 seconds. The DSA stated the sanitizing solution is used to sanitize the food preparation area to reduce the number of bacteria on non-food contact surfaces. The incomplete log indicated the facility's kitchen was not sanitized according to the facility's policy. During an interview with the DS on 10/21/2024 at 9:47 AM, when asked about the procedure of completing the Sanitizer Solution Log, the DS stated that the staff is supposed to fill out the log after testing the water. If the PPM is not at the acceptable range, a new water bucket with sanitizing agent must be retested and change more often as needed. The DS verified that log entries for the dates mentioned above were missing. DS stated it is the responsibility of the DSA to oversee the staff when he is not here. He is only part-time at this facility. The DS stated that every kitchen staff member must complete the log. The DS said he would follow up and make sure everyone follows through. The DS stated he would ensure the log was filled out accurately and consistently. During a review of the facility's policy and procedure (P&P) titled, Quaternary Ammonium Log Policy, indicated the concentration of the ammonium in the quaternary sanitizer will be tested to ensure the effectiveness of the solution. Food and Nutrition Services staff will record the readings twice a day, once in the morning and once in the PM, to document the process was completed.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 47467 Based on observation, interview, and record review, the facility's Quality Assessment and Assurance committee (QAA, committee established for the purpose of improving the safety and quality of health services) failed to establish and implement written policies and procedures to address noncompliance to the facility's smoking policy for 8 out of 28 residents (Resident 2, 3, 9, 14, 18, 56, 67 and 136) who were smokers, by failing to: 1. Identify quality deficiencies related to noncompliance with the facility's smoking policy. 2. Ensure effective oversight of the facility's smoking area. 3. Ensure effective system to obtain input from the Activity Director (AD) 1 to develop and implement appropriate plan of action to address noncompliance with the facility's smoking policy. This failure resulted in eight residents (Resident 2, 3, 9, 14, 18, 56, 67 and 136) smoking unsupervised during nonscheduled smoking time, which had the potential for the residents to be at risk for accidental burn, fire hazards that could affect the health, safety, wellbeing of residents, staffs, visitors. Cross Reference to F689. Findings: During an interview on 10/21/2024 at 8:45 AM, the Director of Nurses (DON) stated, the DON was covering and acting as the facility's Administrator. During an observation on 10/21/2024 from 9 AM to 4 PM, a total of eight residents were observed smoking with no staff supervision during nonscheduled smoking time (The facility's scheduled smoking time were: 8AM-9AM, 1PM-2PM, 6PM-7PM), two of the eight observed smoking residents had cigarette lighters in their possession. During an interview on 10/21/2024 at 5:22 PM with the Activity Staff (AS) 1, AS 1 stated, he was aware that some residents were noncompliant with the facility's smoking policy. AS 1 stated, he reported to the previous AD (AD 1), who no longer worked in the facility for the last 2 weeks. AS 1 stated, some residents had their own lighters and cigarettes from their families, relatives, and friends. AS 1 stated, he could not do anything to stop the residents because the residents could get mad and kept bugging him until they could smoke as they wanted. AS 1 stated, he had to let the residents smoke cigarettes as they wanted and did not know what to do. During an interview on 10/22/2024 at 12:01 PM with the AD 2, the AD 2 stated, she was hired since 10/11/2024 but officially worked as an AD since 10/21/2024. The AD 2 stated, when a resident was noncompliant with the smoking policy, the facility's staff needed to follow their policy for noncompliance with smoking to know what to do. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/22/2024 at 2:20 PM with the DON, the DON stated the facility did not have any policy on the interventions to implement for noncompliance with smoking. The DON stated, a policy for noncompliance with smoking was important because it was a guidance for staffs to know what to do, what not to do. The DON stated without the policy, the staffs would not know how to address the noncompliance with smoking. During an interview on 10/24/2024 at 5:10 PM with the DON, the DON stated, she was aware that some residents were noncompliant with their smoking policy because AD 1 had brought up his concern during the daily stand-up staff meeting in the past. The DON stated, due to the lack of oversight, they did not have any noncompliance policy related to smoking, which resulted in residents smoking unsupervised during nonscheduled smoking time and had a potential risk for the residents to have accidental burns or fire. The DON stated, AD 1's concern should have been prioritized due to residents' safety and discussed during their monthly QAA meeting to make improvement and to develop a noncompliance policy for smoking. During a review of the facility's policy and procedure (P&P) titled, Quality Assurance and Performance Improvement (QAPI) Program, revised February 2020, the P&P indicated the following: - The facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for the residents. -The objectives of the QAPI programs are to provide a means to measure current and potential indicators for outcomes of care and quality of life; provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators. -The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process include tracking and measuring performance and identifying and prioritizing quality deficiencies.

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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** 46779 Based on observation, interview, and record review, the facility failed to ensure the standard infection control practices were followed by: 1. Failing to follow the facility's policies and procedures (P&P) Cleaning and Disinfection of Resident-care Items and Equipment for two of two sampled residents (Resident 46 and 71) as evidenced by the blood pressure cuff (a device used to measure the blood pressure [BP, the force of the blood pushing against the walls of the arteries [tubelike structures transporting blood from the heart to the rest of the body]) and the BP monitor (a small portable device that records BP readings) was not cleaned and disinfected (remove dirt or stains, and apply a chemical to a surface in order to destroy germs) before and after each use. 2. Failing to provide a surveillance system to monitor the facility's water system that serves 84 of 84 residents in the facility and to identify presence of Legionella (a disease-causing organism that may be transmitted through microscopic water droplets that have been contaminated and may be inhaled into a person ' s lungs and cause Legionnaires' disease [a serious type of pneumonia that was characterized by fever, muscle pain, and cough] or Pontiac fever [a mild, flu-like illness]). These deficient practices placed Resident 71 at risk for contracting infections from contaminated medical device. These deficient practices also had the potential to result in the spread of Legionnaires' disease within the facility and residents, staffs, and contractors who used the water system in the facility. Findings: 1. During a review of Resident 46's Admission Record indicated the facility originally admitted Resident 46 on 2/14/2023 and readmitted on [DATE] with diagnoses that included schizophrenia (a chronic mental illness that affects a person's thoughts, feelings, and behaviors) and anemia (a blood disorder that occurs when your body doesn't produce enough healthy red blood cells [a type of blood cell that transport oxygen and nutrients throughout the body] or the red blood cells you have don't function properly). During a review of Resident 46's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/15/2024, indicated Resident 46 had intact memory and cognition (ability to think and reasonably). During a review of Resident 71's Admission Record indicated the facility originally admitted Resident 71 on 6/13/2023 and readmitted on [DATE] with diagnoses that included chronic congestive heart failure (a serious condition that occurs when the heart can't pump enough blood to meet the body's needs) and anemia. During a review of Resident 71's MDS, dated [DATE], indicated Resident 71 had intact memory and cognition (ability to think and reasonably). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 10/22/2024 at 8:01 AM, Licensed Vocational Nurse (LVN) 4 applied a BP cuff to Resident 46's right arm and used the BP monitor to check Resident 46's BP, then, LVN 4 placed the used BP cuff and the BP monitor on top of the medication cart without cleaning and disinfecting. During an observation on 10/22/2024 at 8:11 AM, LVN 4 took the BP cuff and the BP monitor that were not disinfected from the top of the medication cart and used it to check Resident 71's BP. During an interview on 10/22/24 at 8:12 AM, with LVN 4, LVN 4 stated she did not disinfect the BP cuff and the monitor after using them on Resident 46 and did not disinfect them before using them on Resident 71. LVN 4 stated she should disinfect the BP cuff and the monitor after and before each use to prevent the spread of infection to the residents. During an interview on 10/24/2024 at 4:45 PM, with the DON, the DON stated reusable equipment should be clean and disinfected before and after each use to prevent transmission of infection. During a review of the facility's P&P titled, Cleaning and disinfection of Resident-Care Items and Equipment, dated 9/2022, the P&P indicated Reusable items are cleaned and disinfected .between residents (e.g., stethoscopes, durable medical equipment). 50203 2. During a concurrent observation and interview on 10/23/2024 at 9:15 AM with the Maintenance Supervisor (MS), there was no documentation that the facility tested their water management system for Legionella. The MS stated, the facility conducted their own testing for Legionella with a minilab test kit. The MS stated, the water system was tested for Legionella, and the results were recorded in the previous administrator's phone. The MS stated the previous administrator was no longer employed by the facility and had been out for about two months. The MS stated, it was important to test for Legionella because Legionella can survive in water and grow in human-made water systems. The MS stated residents, staff, and visitors were at risk for developing Legionella because everyone uses the water system. During an interview on 10/23/2024 at 9:44 AM with the Director of Nursing (DON), the DON stated, it was important to test for water safety because it could affect everyone in the facility. During an interview on 10/23/2024 at 10:12 AM with the Infection Preventionist (IP), the IP stated, it was important to ensure that there was no Legionella in the facility because all the residents, staff, and contractors who use the water system were affected. During a review of the facility's policy and procedures (P&P), titled Legionella Water Management Program dated 9/2022, the P&:P indicated the water management program included specific measures used to control the introduction and/or spread of Legionella by having control limits or parameters that are acceptable and monitored, and a system to monitor the control limits and the effectiveness of control measures.

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on observation, interview, and record review, the facility failed to ensure five (5) out of thirty (30) resident's rooms (room [ROOM NUMBER], 32, 33, 34, and 35) accommodated no more than four residents in each room. All 5 resident rooms consisted of six (6) bed capacity. This deficient practice had the potential adversely affect the delivery of care, quality of life, safety and violate the resident's rights for privacy. Findings: During the entrance conference interview, the Director of Nurses (DON) on 10/21/2024 at 8:45 AM, the DON stated there were five rooms (room [ROOM NUMBER], 32, 33, 34, and 35) in the facility that did not meet the federal regulation [a regulation that the Long-Term Facilities was required to follow to meet federal requirement of by Centers for Medicare & Medicaid Services (CMS)] for no more than four residents in each room. The DON stated, the facility had a Room Variance Waiver (a permit approved for rooms that did not meet the regulation requirement) in place and would like to request an additional waiver this year. The DON stated, the multiple beds per room had no impact on care of the residents. During a concurrent observation and interview on 10/21/2024 at 9:15 AM in room [ROOM NUMBER], room [ROOM NUMBER] had 6 beds, each bed had their own drawers. In the room, Resident 4 was observed ambulating around the room with no difficulty. Resident 4 stated, she had no concern with the space and felt like she had enough space to move around with her wheelchair. During a concurrent observation and interview on 10/21/2024 at 9:50 AM in room [ROOM NUMBER], room [ROOM NUMBER] had 6 beds, each bed had their own drawers. Resident 50 was observed lying in bed. Resident 50 stated, he can walk around the room with no difficulty and had no concern with limited space. During a concurrent observation and interview on 10/21/2024 at 11:10 AM in room [ROOM NUMBER], room [ROOM NUMBER] had 6 beds, each bed had their own drawers. Resident 24 stated, he had no concern with the room size, and stated, the facility staffs and him were able to move around freely. During an observation on 10/21/2024 at 12:05 PM in room [ROOM NUMBER], room [ROOM NUMBER] had 6 beds, each bed had their own drawers. Resident 14 was observed walking around the room with no difficulty and no concern with limited space. During a concurrent observation and interview on 10/21/2024 at 12:24 PM in room [ROOM NUMBER], room [ROOM NUMBER] had 6 beds, each bed had their own drawers. Resident 82 stated, he had enough space for his belongings and move around comfortably. During a review of the facility's Client Accommodations Analysis, dated 10/24/2024, indicated the facility had 5 rooms (room [ROOM NUMBER], 32, 33, 34, and 35) that had more than four residents per room. (continued on next page)

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	During a review of the facility's request letter for room waiver, dated 10/24/2024, indicated room [ROOM NUMBER], 32, 33, 34, and 35 had 6 resident's beds in each room. The room waiver indicated having more than 4 residents in each room had no adverse effect in the health, safety, or in maintaining the wellbeing of the residents, and the facility attempted to ensure that residents' needs were met. The record also indicated; the facility will ensure: - Residents' wheelchair can freely move in and out of the toilet as needed. - Residents' room can have space for at least one visitor's chair. - Residents' room can have space for a bedside table (nightstand), over the bed table, and a built-in closet for their belongings. - If a resident expresses discomfort from the room and space, the said resident will be relocated to an available room that meets their needs. - The residents' needs and concerns regarding room and comfort will be identified during room rounds, which are conducted by the ADM and the IDT. - Residents that express concerns regarding room and comfort will be discussed during the IDT meeting for proper interventions to take place. During a review of the facility's Resident Census from the last Health Recertification Survey with exit date of 11/2/2023, indicated the residents that occupied room [ROOM NUMBER], 32, 33, 34, and 35 were not the same residents that currently occupies room [ROOM NUMBER], 32, 33, 34, and 35 during this current Health Recertification Survey for 10/21/2024 to 10/24/2024. During a review of the facility's policy and procedures (P&P) titled, Bedroom, dated May 2017, indicated all residents are provided with clean, comfortable and safe bedrooms that meet federal and state requirements, bedrooms accommodate no more than two residents at a time.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on observation, interview and record review, the facility failed to provide a minimum of 80 square feet (sq. ft., unit of measurement) per resident for five (5) out of thirty (30) resident rooms (room [ROOM NUMBER], 32, 33, 34, and 35). This deficient practice had the potential to negatively impact the quality-of-care and the ability of the nursing care to safely provide care and privacy to the residents. Findings: During the entrance conference interview, the Director of Nurses (DON) on 10/21/2024 at 8:45 AM, the DON stated there were five rooms (room [ROOM NUMBER], 32, 33, 34, and 35) in the facility that did not meet the federal regulation [a regulation that the Long-Term Facilities was required to follow to meet federal requirement of by Centers for Medicare & Medicaid Services (CMS)] to ensure at least 80 square feet of space per resident in each room. The DON stated, the facility had a Room Variance Waiver (a permit approved for rooms that did not meet the regulation requirement) in place and would like to request an additional waiver this year. The DON stated, the lack of space had no adverse effect in the health safety, or in maintaining the wellbeing of the residents. During a concurrent observation and interview on 10/21/2024 at 9:15 AM in room [ROOM NUMBER], room [ROOM NUMBER] had 6 beds, each bed had their own drawers. In the room, Resident 4 was observed ambulating around the room with no difficulty. Resident 4 stated, she had no concern with the space and felt like she had enough space to move around with her wheelchair. During a concurrent observation and interview on 10/21/2024 at 9:50 AM in room [ROOM NUMBER], room [ROOM NUMBER] had 6 beds, each bed had their own drawers. Resident 50 was observed lying in bed. Resident 50 stated, he can walk around the room with no difficulty and had no concern with limited space. During a concurrent observation and interview on 10/21/2024 at 11:10 AM in room [ROOM NUMBER], room [ROOM NUMBER] had 6 beds, each bed had their own drawers. Resident 24 stated, he had no concern with the room size, and stated, the facility staffs and him were able to move around freely. During an observation on 10/21/2024 at 12:05 PM in room [ROOM NUMBER], room [ROOM NUMBER] had 6 beds, each bed had their own drawers. Resident 14 was observed walking around the room with no difficulty and no concern with limited space. During a concurrent observation and interview on 10/21/2024 at 12:24 PM in room [ROOM NUMBER], room [ROOM NUMBER] had 6 beds, each bed had their own drawers. Resident 82 stated, he had enough space for his belongings and move around comfortably. During a review of the facility's Client Accommodations Analysis, dated 10/24/2024, indicated the facility had 5 rooms (room [ROOM NUMBER], 32, 33, 34, and 35) that had more than four residents per room. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During a review of the facility's request letter for room waiver, dated 10/24/2024, indicated room [ROOM NUMBER], 32, 33, 34, and 35 provided 72.33 square feet per resident in each room. The room waiver indicated; the facility will ensure: - Residents' wheelchair can freely move in and out of the toilet as needed. - Residents' room can have space for at least one visitor's chair. - Residents' room can have space for a bedside table (nightstand), over the bed table, and a built-in closet for their belongings. - If a resident expresses discomfort from the room and space, the said resident will be relocated to an available room that meets their needs. - The residents' needs and concerns regarding room and comfort will be identified during room rounds, which are conducted by the ADM and the IDT. - Residents that express concerns regarding room and comfort will be discussed during the IDT meeting for proper interventions to take place. During a review of the facility's Resident Census from the last Health Recertification Survey with exit date of 11/2/2023, indicated the residents that occupied room [ROOM NUMBER], 32, 33, 34, and 35 were not the same residents that occupies room [ROOM NUMBER], 32, 33, 34, and 35 during this current Health Recertification Survey for 10/21/2024 to 10/24/2024. During a review of the facility's policy and procedures (P&P) titled, Bedroom, dated May 2017, indicated all residents are provided with clean, comfortable and safe bedrooms that meet federal and state requirements, bedrooms measure at least 80 square feet of space per resident in double rooms.

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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** 50012 Based on observation, interview, and record review, the facility failed to provide and maintain a functioning call light (a device that allows residents to communicate with their care providers when they need assistance) for one of 23 sampled residents (Resident 10). This deficient practice had the potential to result in a delay in meeting the resident's needs for assistance and can lead to falls and accidents. Findings: During a review of the admission record indicated Resident 10 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including but not limited to lack of coordination, chronic obstructive pulmonary disease (COPD, a progressive lung disease that makes it hard to breathe), and cognitive communication deficit. During a review of the Minimum Data Set Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 10/10/2024 indicated Resident 10 had severely impaired cognitive skills for daily decision making and required extensive assistance for bed mobility, transfer, toilet use, personal hygiene, and bathing. During an observation on 10/21/24 at 10:18 AM in Resident 10 room, there was no call light system in the resident ' s room. During a concurrent observation and interview on 10/21/24 at 10:18 AM with CNA 5, when asked how long no call light in the room there had been, she stated that she can does not recall. Stated it is important for the resident to have a call light within reach in case of an emergency. She will inform her charge nurse. During an interview on 10/21/2024 at 10:19 AM with the Register Nurse 1 (RN1), Stated that resident did not have a call light, and it was unacceptable. Stated she will follow up with maintenance. Stated per policy all residents should have a call light within reach to call for assistance. During a review of the facility's policy and procedure (P&P) titled, Call system, revised 2022, indicated 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.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46779 Based on observation, interview and record review, the facility failed to provide a clean and sanitary environment for four of four sampled residents (Residents 58, 60, 66, and 74) by failing to: 1. Ensure Resident 66's oxygen concentrator machine (a medical device that supplies oxygen and it can help people with breathing difficulties breathe more easily) was clean. 2. Ensure the facility maintained an effective pest control in the facility. Three of three residents (Resident 58, 60, and 74) were observed in the dining room with flies while eating their meals. These deficient practices had the potential for Resident 66 to have an allergic reaction from the dust and had a potential to result in Resident 58, 60, and 74's food contamination transfer of disease-causing organism from the flies from one contact area to another that could result in infection. Findings: 1. During a review of Resident 66's Admission Record indicated the facility admitted Resident 66 on 7/1/2022 with diagnoses that included anxiety disorder (a mental health condition that involves persistent and excessive worry that interferes with daily activities) and dementia (a chronic condition that causes a decline in mental abilities, such as thinking, remembering, and reasoning, that interferes with daily life). During a review of Resident 66's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 10/10/2024, indicated Resident 66 had severely impaired cognitive (ability to think and reason) skills for daily decision making. The MDS indicated Resident 66 required substantial/maximal assistance with toileting hygiene, and was dependent with eating, oral hygiene, shower/bathe self, and personal hygiene. During a review of Resident 66's Order Summary Report, dated 9/30/2024, indicated the physician ordered to administer oxygen at two liter per minute (PLM, a unit of measurement). During an observation on 10/21/2024 at 9:52 AM, Resident 66 was lying on the bed and receiving oxygen delivery through a tubing. The oxygen tubing was connected to a blue oxygen concentrator machine located on the floor on the right of the bed with a layer of accumulated white dust was on top of the oxygen concentrator machine. During an observation on 10/21/2024 at 10:05 AM, with Licensed Vocational Nurse (LVN) 3, LVN 3 stated it was a layer of dust that accumulated on top of the oxygen concentrator machine, and it should be cleaned to maintain a sanitary environment for the resident ' s comfort and prevent infection. LVN 3 stated she did not notice there was dust on top of the machine until the surveyor informed her. LVN 3 stated she did not know for how long the staff had not wipe and clean the machine. LVN 3 stated LVNs and Certified Nursing assistants (CNAs) were responsible to wipe and clean the oxygen concentrator machine. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/24/2024 at 4:48 PM, with the Director of Nursing (DON), the DON stated reuseable medical equipment should be cleaned and disinfected if soiled to provide a sanitary and comfortable environment for the residents. 2a. During a review of Resident 58's Admission Record indicated the facility originally admitted Resident 58 on 7/26/2024 and readmitted her on 2/12/2024 with diagnoses that included heart failure (a serious condition that occurs when the heart is unable to pump enough blood to meet the body's needs) and hyperlipidemia (a condition where there are abnormally high levels of fats in the blood). During a review of Resident 58's MDS, dated [DATE], indicated Resident 58 had moderately impaired memory and cognition. The MDS indicated Resident 58 required supervision or touching assistance with eating, partial/moderate assistance with oral hygiene and toileting hygiene, and substantial/maximal assistance with shower/bathe self and chair/bed-to-chair transfer. 2b. During a review of Resident 60's Admission Record indicated the facility originally admitted Resident 60 on 1/25/2022 and readmitted her on 8/12/2024 with diagnoses that included anxiety disorder and dementia. During a review of Resident 60's MDS, dated [DATE], indicated Resident 60 had intact memory and cognition. The MDS indicated Resident 60 required setup or clean-up assistance with oral hygiene and personal hygiene, and supervision or touching assistance with eating, toileting hygiene, shower/bathe self, and chair/bed-to-chair transfer. 2c. During a review of Resident 74's Admission Record indicated the facility admitted Resident 74 on 1/18/2024 with diagnoses that included dementia and encephalopathy (a group of conditions that cause brain dysfunction). During a review of Resident 74's MDS, dated [DATE], indicated Resident 74 had severely impaired cognitive skills for daily decision making. The MDS indicated Resident 74 required supervision or touching assistance with eating, oral hygiene and personal hygiene, and partial/moderate assistance with toileting hygiene, shower/bathe self, and chair/bed-to-chair transfer. During an observation on 10/21/24 at 12:14 PM, residents were eating lunch in the dining room. Resident 60, Resident 74 and Resident 58 were sitting at the same table with their food uncovered on the table. A fly flew over their food. Resident 60, Resident 74 and Resident 58 shooed away the fly with their hands that was trying to land on their food. Certified Nursing Assistant (CNA) 6, who was sitting at the same table providing assistance, also shooed away the fly for the residents. The Physical Therapy Assistant (PTA), who was sitting at the table next Resident 60, 74, and 58, got up and helped to shoo away the fly for them. During an interview on 10/21/2024 at 12:15 PM, with the PTA, the PTA stated she saw a fly in the dining room, and she tried to shoo away the fly that was trying to land on residents ' food to make sure the food was clean. The PTA stated to prevent residents from consuming contaminated food which could get them sick. During an interview on 10/21/2024 at 12:16 PM, with CNA 6, CNA 6 stated she saw a fly in the dining room, and she shooed away for the residents, so the fly would not land on the food and contaminated the food. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/21/2024 at 12:36 PM, with Resident 60, Resident 60 stated she sometimes see flies in the dining room for the past two months and the residents reported to the facility, but the facility did not do anything about it. Resident 60 stated it was annoying to having flies around inside the facility and she was worried the residents would get sick from ingesting food that were contaminated by flies. During an interview on 10/24/24 at 4:38 PM, with the Infection Preventionist (IP), the IP stated it had been a problem with flies in the facility because the building was next to a horse stable. The IP stated flies should not be in facility to prevent the spread of infection. During a review of the facility's policy and procedure (P&P) titled, Pest Control, dated 5/2008, indicated the facility ensure that the building is free of insects. During a review of the facility's P&P titled, Homelike Environment, dated 2/2021, indicated the facility ensure residents were provided with a clean, sanitary and orderly environment.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 47467 Based on observation, interview, and record review, the facility failed to maintain an effective pest control program by ensuring the supply room containing enteral nutrition (a form of nutrition delivered through a tube into the digestive system as a liquid) and other food products did not have any cockroaches and pests. This failure had the potential for the residents to contract illnesses, including food borne illnesses [an illness that comes from eating contaminated (containing disease causing organism) food] brought in by the pest and cockroaches. Findings: During an observation on 10/23/2024 at 10:00 AM, the supply room had one large brown cockroach approximately two inches in length that was alive and was on the floor under a metal storage shelf rack containing boxes of canned enteral nutrition. During a concurrent observation and interview on 10/24/2024 at 10:05 AM with the Infection Preventionist (IP, a healthcare professional who works to prevent the spread of infections in healthcare facilities) inside the facility 's storage room, a large, live, brown cockroach was on the floor. The IP stated, It is a cockroach, still alive. The IP stated, the facility stored enteral nutrition formula and cleaning supplies in the storage room. The IP stated the cockroache should not get in the storage room because it could contaminate the food products and spread disease. During a concurrent interview and record review on 10/23/2024 at 10:20 AM with the Maintenance Supervisor (MS), the facility's exterminator service report (ESR) from 9/10/2024 and 10/11/2024 was reviewed. The ESR, dated 9/10/2024, indicated the technician treated the exterior perimeter of the property with a liquid residual pesticide that included window frames, door frames, dumpster areas, and all cracks and crevices as well as the corners of the kitchen areas. The ESR, dated 10/11/2024, indicated the technician treated the interior perimeter along the kitchen area behind appliances, as well as checking for gnat activity and noted the facility had gnats coming out of clogged drains. The MS stated, the facility had pest control personnel that only came at nighttime and did not come inside the facility to inspect or treat for pest unless requested. The MS stated, the exterminator did not inspect or treat the storage rooms because the facility always locked their supply rooms. The MS stated that the facility should have inspected the supply rooms and had them treated as needed. The MS confirmed that the facility had an ineffective pest control plan. During a record review of the facility's policy and procedure (P&P) titled, Pest Control, dated May 2008, the P&P indicated, This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. During a record review of the facility's P&P titled, Storage of Food and Supplies, dated 2023, the P&P indicated, Routine cleaning and pest control procedures should be developed and followed.