STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056113	A. Building B. Wing	12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alexandria Care Center	1515 N Alexandria Ave. Los Angeles, CA 90027

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 42311 Based on interview and record review, the facility failed to develop a comprehensive care plan for one of three sampled residents (Resident 5) who was refusing to shower. This deficient practice had the potential for delayed provision of necessary care and services. Findings: During a record review of Resident 5's Admission Record, the Admission record indicated the facility admitted Resident 5 on 12/7/2022, with diagnoses that included other partial intestinal obstruction (the intestine is only partially blocked, allowing some food, liquid, and gas to pass through, but not a complete blockage where nothing can move through), left shoulder bicipital tendinitis (inflammation of the tendon that connects the biceps muscle to the shoulder and elbow), and primary osteoarthritis (causes joint pain, swelling, and tenderness that can affect a person's mobility and quality of life). During a record review of Resident 5's History and Physical (H&P- a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 5/29/2024, the H&P indicated Resident 5 had the capacity to understand and make decisions. During a record review of Resident 5's Minimum Data Set (MDS a federally mandated resident assessment tool), dated 12/8/2024, the MDS indicated Resident 5 had intact cognitive skills for daily decisions. The MDS indicated Resident 5 was dependent to staff for showering and bathing. During an interview on 12/31/2024 at 8:54 a.m., Certified Nursing Assistant 1 (CNA 1), CNA 1 stated Resident 5 had refused shower. During an interview on 12/31/2024 at 9:04 a.m., with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated Resident 5 refused shower because she (Resident 5) did not want to get out of bed. LVN 4 stated she was not sure if there was a care plan for shower refusal. During an interview on 12/31/2024 at 9:09 a.m., with CNA 2, CNA 2 stated she had offered shower to Resident 5 and Resident 5 refused. CNA 2 stated she (CNA 2) reported the refusal to the LVN. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/31/2024 at 9:44 a.m., with the Director of Nursing (DON), Resident 5's Documentation Survey Report on bathing dated 12/2024 and care plan on refusing shower dated 12/31/2024 was reviewed. The DON stated there were no documented shower provided to Resident 5 on 12/2024 only bed bath. The DON stated nurses should have initiated a care plan for Resident 5's refusal for shower on 12/1/2024. The DON stated care plan was created late. During a concurrent interview and record review on 12/31/2024 at 11:05 a.m., with the DON, facility's policy and procedure (PP) titled, Goals and Objective, Care Plans, dated 4/2009 and last reviewed on 1/2024, the PP indicated, 1. Care plan goals and objectives are defined as the desired outcome for a specific resident problem. 2. When goals and objectives are not achieved, the resident's clinical record will be documented as to why the results were not achieved and what new goals and objectives have been established. Care plans will be modified accordingly. The resident has the right to refuse to participate in establishing care plan goals and objectives. When such refusals are made, appropriate documentation will be entered into the resident's clinical records in accordance with established policies.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 42311 Based on interview and record review, the facility failed to ensure a resident was provided supervision to prevent elopement (the act of leaving a facility unsupervised and without prior authorization) for one of three sampled residents (Resident 4). On 12/17/2024, at 7:10 p.m., Resident 4 walked out of the facility unassisted with no front wheel walker (FWW- a mobility aid that helps people with limited upper body strength or who need help bearing weight while walking). This deficient practice resulted to Resident 4's elopement and can potentially place Resident 4 at risk for injury, fall and accidents. Findings: During a record review of Resident 4's Admission Record, the Admission Record indicated the facility admitted Resident 4 on 11/1/2023, with diagnoses that included unspecified (unconfirmed) anemia (a condition where the body does not have enough healthy red blood cells), alcohol abuse (a pattern of drinking too much alcohol too often) and personal history of transient ischemic attack (TIA- or mini stroke, happens when there's a temporary disruption in the blood supply to part of the brain) and cerebral infraction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it) without residual effects (the ongoing, lingering effects on the body). During a record review of Resident 4's History and Physical (H&P- a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 11/8/2023, the H&P indicated Resident 4 had the capacity to understand and make decisions. During a record review of Resident 4's Order Summary Report, dated 11/21/2023, the Order Summary Report indicated Restorative Nursing Assistant (RNA) for ambulation using FWW daily five times a week as tolerated. During a record review of Resident 4's Minimum Data Set (MDS- a resident assessment tool), dated 11/5/2024, the MDS indicated Resident 4's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 4 used walker and wheelchair (a mobility device that helps people move around when they have difficulty walking or are unable to walk) for mobility. The MDS indicated Resident 4 required assistance from staff for (personal hygiene and toileting). During a record review of Resident 4's Care Plan on at risk for falls related to limited mobility and poor safety awareness, dated 11/18/2024, the Care Plan indicated an intervention to provide verbal cues for safety and sequencing when needed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 4's Change in Condition Evaluation (CIC), dated 12/17/2024, timed at 7:30 p.m., the CIC indicated on 12/17/2024, at 7:13 p.m., Family Member 1 (FM 1) called the facility and informed the facility that Resident 4 called FM 1 and Resident 4 stated he (Resident 4) was between Street C and D (three blocks away from the facility) trying his (Resident 4) way back to FM 1's house. The CIC indicated at 7:15 p.m., staff were alerted that Resident 4 left the facility and at 7:16 p.m., Licensed Vocational Nurse (LVN) drove around the facility to look for the patient. At 7:30 p.m., found Resident 4 along Street C between Street D and Street E. The CIC indicated FM 1 drove with Resident 4 and Resident 4 was dropped off at the facility. The CIC indicated at 7:35 p.m., FM 1, Director of Nursing (DON), Administrator (ADM) and physician were notified. During a record review of Resident 4's Progress Notes (PN), dated 12/18/2024, timed at 7:50 a.m., the PN indicated Resident 4 did not go out on pass and FM 1 was not at the facility on 12/17/2024. During a record review of Resident 4's Progress Notes (PN), dated 12/18/2024, timed at 8:06 a.m., the PN indicated last time FM 1 visited Resident 4 in the facility was on 12/12/2024. During an interview on 12/31/2024, at 9:40 a.m., RNA stated Resident 4 ambulates with FWW per rehabilitation recommendation for safety. During an interview on 12/31/2024, at 9:44 a.m., the Director of Nursing (DON) stated on 12/17/2024, the facility had a candlelight dinner with visitors and residents. The DON stated Resident 4 attended with no family members. The DON stated Resident 4 left the facility at 7:10 p.m. from the front entrance. The DON stated at 7:13 p.m., the Infection Preventionist (IP) received a called from FM 1 that Resident 4 was outside of the facility between Street C and Street D. The DON stated LVN 1 and LVN 2 drove outside to search and found Resident 4 talking on the phone while walking with no FWW towards the facility. The DON stated Resident 4 had no injury. The DON stated Receptionist (RCP) thought Resident 4 was a visitor and RCP let him (Resident 4) go out. The DON stated elopement can result in fall and accidents. During a concurrent interview and record review on 12/31/2024, at 11:05 a.m., with the DON, facility's policy and procedure (PP), titled, Accidents and Incidents-Investigating and Reporting, dated 7/2017 and last reviewed on 1/2024. The DON stated the PP did not indicate accidents or elopement prevention. During a concurrent interview and record review on 12/31/2024, at 11:06 am with the DON, facility's PP titled, Elopement of Resident, dated 7/12/2023, was reviewed. The PP indicated, Residents will be evaluated for elopement risk upon admission, re-admission, quarterly and with a change in condition as part of the clinical assessment process. Those determined to be at risk will receive appropriate interventions to reduce risk and minimize injury. 3. Unwitnessed Elopement 3.1 Notify the supervisor that the patient is missing. 3.2 Supervisor will alert all staff of missing patient with an announcement to activate missing patient protocol. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.3 A designee from each unit and department will report to the location that announced the missing patient to learn of the patient's name, when the patient was last seen, and a description of the patient. 3.4 Staff will search: 3.4.1. Room to room and all areas of the Facility (including occupied and unoccupied spaces): patient rooms, closets, under beds, shower rooms, utility rooms, offices, dining rooms, stairwells, laundry, kitchen (including walk-in refrigerators and freezers), bathrooms, dayrooms/lounges, courtyards, and employee lounges; and 3.4.2 Outside building perimeter and grounds. During an interview on 12/31/2024, at 11:10 a.m., the ADM stated they do not have a general PP for accident prevention, only specific for elopement or fall. During an interview on 1/3/2025, at 8:31 a.m., the RCP stated she (RCP) saw Resident 4 left the facility from the main front door but assumed he (Resident 4) was a visitor. The RCP stated she (RCP) did not notice if Resident 4 had the resident name tag (wrist name tag). During an interview on 1/3/2025, at 10:04 a.m., LVN 3 stated he (LVN 3) was the assigned nurse for Resident 4 on 12/17/2024. LVN 3 stated on 12/17/2024, at 7 p.m., he (LVN 3) gave Resident 4 a Tylenol (medication used to treat pain) for complaints of back pain. LVN 3 stated at 7:13 p.m., he (LVN 3) was informed that Resident 4 was outside three blocks away from the facility. LVN 3 stated Resident 4 can ambulate but ambulates with FWW for safety. LVN 3 stated elopement can result to fall, injury and worst can cause death. During an interview on 1/3/2025, at 10:47 a.m., the IP stated on 12/17/2024, around 7 p.m., he (the IP) was in his office when the phone rang in the nurse's station and when he (the IP) answered, FM 1 reported that Resident 4 was outside. The IP stated he looked in Resident 4's room and overhead paged (a network of speakers and microphones that allows for announcements and instructions to be broadcast throughout the facility) code (set of color-coded emergency signals that facility uses to convey critical information quickly and efficiently) pink for elopement. During an interview on 1/3/2025, at 11:37 a.m., LVN 1 stated she (LVN 1) was in station 1 when she heard the code pink called by the IP. LVN 1 stated she (LVN 1) and LVN 2 went on the same car and drove around to look for Resident 4. LVN 1 stated Resident 4 was found walking towards the facility along Street C and Street D, three blocks away from the facility. LVN 1 stated Resident 1 did not have the FWW. During an interview on 1/3/2025, at 11:45 a.m., LVN 2 stated he (LVN 2) was in station 3 when he heard the code pink. LVN 2 stated he and LVN 1 drove outside using one car and found Resident 4 three blocks away from the facility. LVN 2 stated Resident 4 had no injury and was walking with no FWW towards the facility's direction. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of facility's policy and procedure (PP) titled, Elopement of Residents, dated 7/12/2023, and last reviewed on 1/2024, the PP indicated, Witnessed Attempted or Actual Elopement, Staff witnessing a confused patient or an identified elopement risk patient attempting to leave the Unit and/or Facility unaccompanied will intervene as appropriate to redirect the patient to a safe area and prevent elopement. If the patient cannot be redirected, alert other staff members to notify the supervisor and stay with the patient until he or she is safely returned to the unit and or facility.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 42311 Based on observation, interview, and record review, the facility failed to ensure the enteral feeding (a way of delivering nutrition directly to the stomach or small intestine) for two of three sampled residents (Resident 1 and Resident 2) were managed by failing to: 1. Ensure Resident 1 and Resident 2 had their enteral feeding supplies labeled with the licensed nurse's signature, date, and time. 2. Ensure Resident 1 received the enteral feeding at the required time. 3. Ensure Resident 1 and Resident 2's total amount of enteral feedings were monitored. These deficient practices had the potential to result in residents receiving inaccurate amount of formula as ordered and enteral feeding supplies harboring bacteria and transmitting to residents. Findings: a. During a concurrent observation and interview on 12/30/2024 at 12:35 p.m., with Registered Nurse 2 (RN 2), observed Resident 1's enteral feeding water bag without a signature of the licensed nurse, dated 12/30/2024 at 12:00 a.m., was connected to the resident. Resident 1's enteral feeding machine was turned on and was set at 40 milliliters (ml - unit of measurement) per hour. Resident 1's enteral feeding formula bag had 600 ml more to infuse but the machine indicated there were 427 ml of formula left to infuse. Resident 1's enteral feeding machine indicated the resident received 2,213 ml of formula. RN 2 stated enteral feedings were for the resident's nutrition. RN 2 stated Resident 1's enteral feeding machine should not be turned on until 1 p.m. per physician orders. RN 2 stated Resident 1's enteral feeding machine setting should be cleared at the end of every shift to ensure the amount the resident received was accurate. RN 2 stated Resident 1 had the potential to receive inaccurate feeding volume. RN 2 stated Resident 1's enteral feeding water bag should indicate the date and time it was changed. RN 2 stated Resident 1 had the potential for infection. During a record review of Resident 1's Admission Record indicated the facility admitted the resident on 1/13/2016 and readmitted the resident on 8/18/2023 with diagnoses including dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), attention to gastrostomy (type of artificial opening to the stomach that requires special care), and essential hypertension (an abnormally high blood pressure that was not a result of a medical condition). During a record review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 10/10/2024, the MDS indicated the resident's cognitive (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills were severely impaired. During a record review of Resident 1's Physician Order, dated 4/10/2024, the Physician Order indicated enteral feed order every shift Jevity (a feeding formula) 1.5 calories, administered continuously using a feeding pump at 40 ml per hour for 20 hours per day or until total nutrient delivered of 800 ml per day with downtime of 9 a.m. to 1 p.m. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/30/2024 at 1:18 p.m., the Director of Nursing (DON) stated Resident 1's enteral feeding should be turned on for 20 hours, turned off after the total volume was completed, and turned back on at 1 p.m. per physician order. The DON stated the enteral feeding machine was not cleared. The DON stated these practices had the potential for Resident 1 to receive inaccurate formula volume that could cause the resident's abdominal discomfort and bloating. The DON stated the enteral feeding water bag should indicate the licensed nurse's signature, the date, and the time the bag was changed. The DON stated Resident 1's enteral feeding water bag did not indicate the licensed nurse signature. The DON stated the facility failed to monitor and follow Resident 1's enteral feeding orders. b. During a concurrent observation and interview on 12/30/2024 at 12:54 p.m., with RN 2, observed Resident 2's enteral feeding water bag without a signature of the licensed nurse and the date and time the formula was started, was connected to the resident. Resident 2's enteral feeding formula did not indicate the time the formula whas changed. Resident 2's enteral feeding machine was set at 50 ml per hour. Resident 2's enteral feeding formula bag had 400 ml more to infuse but the machine indicated there were 193 ml of formula left to infuse. Resident 2's enteral feeding machine indicated the resident received 2,160 ml of formula. RN 2 stated enteral feedings were for the resident's nutrition. RN 2 stated Resident 2's enteral feeding machine setting should be cleared at the end of every shift to ensure the amount the resident received was accurate. RN 2 stated Resident 2 had the potential to receive inaccurate feeding volume. RN 2 stated Resident 2's enteral feeding water and formula bag should indicate the date and time it was changed. RN 2 stated Resident 2 had the potential for infection. During a record review of Resident 2's Admission Record indicated the facility admitted the resident on 10/29/2020 and readmitted the resident on 11/18/2022 with diagnoses including Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination) without dyskinesia (involuntary, erratic, writhing movements of the face, arms, legs or trunk), attention to gastrostomy, and cerebral palsy (a group of conditions that affect movement and posture). During a record review of Resident 2's MDS, dated [DATE], the MDS indicated the resident's cognitive skills were moderately impaired. During a record review of Resident 2's Physician Order, dated 5/8/2023, the Physician Order indicated enteral feed order every shift Jevity 1.5 calories, administered continuously using a feeding pump at 50 ml per hour for 20 hours per day or until total nutrient delivered of 1000 ml per day. During an interview on 12/30/2024 at 1:18 p.m., the DON stated Resident 2's enteral feeding machine was not cleared at the end of the 11 p.m. to 7 a.m. shift or at the start of the 7 a.m. to 3 p.m. shift. The DON stated this practice had the potential for Resident 2 to receive inaccurate formula volume that could cause the resident's abdominal discomfort and bloating. The DON stated the enteral feeding water bag and formula bag should indicate the licensed nurse's signature, the date, and the time the bag was changed. The DON stated Resident 1's enteral feeding water bag did not indicate the licensed nurse signature and the date and time the bag was changed. The DON stated Resident 1's enteral feeding formula bag did not indicate the time the bag was changed. The DON stated the facility failed to monitor and follow Resident 1's enteral feeding orders. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of the facility's policy and procedure (PnP) titled, Closed Enteral Feeding, last reviewed on 1/2024, the PnP indicated the enteral feeding will be administered via pump as ordered by the Attending Physician. The Procedure section on the PnP indicated to calculate amount of formula to be given per shift per Attending Physician's order, label the formula with date and time, set dose limit on the machine, and document administration of enteral feeding in the resident's medical records.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42311 Based on interview and record review, the facility failed to maintain accurate and complete medical record for two of three sampled residents (Resident 4 and Resident 5) by: 1. Failing to accurately document Resident 4's history of elopement (the act of leaving a facility unsupervised and without prior authorization) in the Elopement Evaluation on 12/17/2024 after Resident 4 had elope. 2. Failing to accurately document shower was provided to Resident 5 on 12/2024. These deficient practices had the potential to cause confusion in care and the medical records containing inaccurate documentation. Findings: a. During a record review of Resident 4's Admission Record, the Admission Record indicated the facility admitted Resident 4 on 11/1/2023, with diagnoses that included unspecified (unconfirmed) anemia (a condition where the body does not have enough healthy red blood cells), alcohol abuse (a pattern of drinking too much alcohol too often) and personal history of transient ischemic attack (TIA- or mini stroke, happens when there's a temporary disruption in the blood supply to part of the brain) and cerebral infraction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it) without residual effects (the ongoing, lingering effects on the body). During a record review of Resident 4's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 11/8/2023, the H&P indicated Resident 4 had the capacity to understand and make decisions. During a record review of Resident 4's Minimum Data Set (MDS- a resident assessment tool), dated 11/5/2024, the MDS indicated Resident 4's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 4 used walker and wheelchair (a mobility device that helps people move around when they have difficulty walking or are unable to walk) for mobility. The MDS indicated Resident 4 required assistance from staff for (personal hygiene and toileting). During a record review of Resident 4's Change in Condition Evaluation (CIC), dated 12/17/2024, timed at 7:30 p.m., the CIC indicated on 12/17/2024, at 7:13 p.m., Family Member 1 (FM 1) called the facility and informed the facility that Resident 4 called FM 1 and Resident 4 stated he (Resident 4) was between Street C and D (three blocks away from the facility) trying his (Resident 4) way back to FM 1's house. The CIC indicated at 7:15 p.m., staff were alerted that Resident 4 left the facility and at 7:16 p.m., Licensed Vocational Nurse (LVN) drove around the facility to look for the patient. At 7:30 p.m., found Resident 4 along Street C between Street D and Street E. The CIC indicated at 7:35 p.m., FM 1, Director of Nursing (DON), Administrator (ADM) and physician was notified. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/31/2024, at 9:44 a.m., with the DON, Resident 4's Elopement Evaluation dated 12/17/2024, timed at 11:26 p.m. was reviewed. The Elopement Evaluation indicated Resident 4 had no history of actual elopement or attempted elopement. The DON stated Registered Nurse 1 (RN 1) should have documented yes that Resident 4 had history of elopement since Resident 4 eloped on 12/17/2024, at 7:10 p.m. earlier that day. b. During a record review of Resident 5's Admission Record, the Admission record indicated the facility admitted Resident 2 on 12/7/2022 with diagnoses that included other partial intestinal obstruction (the intestine is only partially blocked, allowing some food, liquid, and gas to pass through, but not a complete blockage where nothing can move through), left shoulder bicipital tendinitis (inflammation of the tendon that connects the biceps muscle to the shoulder and elbow) and primary osteoarthritis (causes joint pain, swelling, and tenderness that can affect a person's mobility and quality of life). During a record review of Resident 5's H&P, dated 5/29/2024, the H&P indicated Resident 5 had the capacity to understand and make decisions. During a record review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5 had intact cognitive skills for daily decisions. The MDS indicated Resident 5 was dependent to staff for showering and bathing. During an interview on 12/31/2024 at 9:04 a.m., with LVN 4, LVN 4 stated Resident 5 had been showered but mostly bed bath per Resident 5 preference. LVN 4 stated Resident 5's shower schedule was on Wednesdays and Saturdays. During a concurrent interview and record review on 12/31/2024 at 9:44 a.m., with the DON, Resident 5's Documentation Survey Report on bathing dated 12/2024 was reviewed. The DON stated there were no documented shower provided to Resident 5 only bed bath and last bed bath provided was on 12/29/2024. The DON stated the importance of shower is for hygiene and to promote dignity. During an interview on 12/31/2024 at 10:39 a.m., Resident 5 stated her (Resident 5) last shower was two weeks ago. During a concurrent interview and record review on 12/31/2024 at 11:10 p.m., with the Administrator (ADM), facility's policy and procedure titled, Charting and Documentation, dated 7/2017 and last reviewed on 1/2024. The ADM stated the PP indicated, Documentation in the medical record will be objective (not opinionated or speculative), complete and accurate.