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	01/31/2025

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

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44244 Based on observation, interview, and record review the facility failed to provide reasonable accommodation of resident needs and preferences by failing to ensure the call light (CL, an alerting device for nurses or other nursing personnel to assist a patient when in need) was within reach for two of three sampled residents (Resident 33 and 94) reviewed under the Environment task. This deficient practice had the potential to result in the delay of care and services and possible injury to residents when they are unable to summon health care workers. Findings: a.During a review of Resident 33's Admission Record, the Admission Record indicated the facility admitted the resident on 11/18/2020 and readmitted the resident on 5/2/2024 with diagnoses that included heart failure (HF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), displaced comminuted fracture (a bone that is broken in at least two places) of the shaft of the right femur (the thigh bone), muscle weakness, reduced mobility, morbid obesity (a serious health condition that results from an abnormally high body mass), and need for assistance with personal care. During a review of Resident 33's Order Summary Report, the report indicated an order for fall precautions (interventions to reduce the occurrence of falls), dated 5/2/2024 During a review of Resident 33's History and Physical (H&P), dated 5/30/2024, the H&P indicated Resident 33 did not have the capacity to make decisions but could make her needs known. During a review of Resident 33's Minimum Data Set (MDS - resident assessment tool) dated 11/12/2024, the MDS indicated Resident 33 was able to understand others and was able to make herself understood. The MDS further indicated the resident had an impairment on one side of the lower extremities, was dependent on staff for toileting and bathing, and required substantial/maximal assistance for personal hygiene and dressing. The MDS indicated Resident 33 required substantial/maximal assistance from staff for bed mobility and was dependent on staff for transfers from the bed to the chair. During a review of Resident 33's Care Plan (CP) titled, Resident is at risk for falls: cognitive loss, lack of safety awareness, history of falls with injury ., initiated 5/2/2024 and last revised 1/6/2025, indicated to arrange the resident's environment to enhance vision and maximize independence. (continued on next page)

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

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

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 1/28/2025 at 9:50 a.m., Resident 33 lying in bed. Resident 33 stated she wanted to go home and did not have a call light to call for assistance. The call light cord was clipped to a string hanging from the light attached to the wall. The call light button was dangling behind Resident 33's bed. Resident 33 stated she can't really move and does not know where the call light is. During a concurrent observation and interview on 1/28/2025 at 9:55 a.m., with Restorative Nurse Aide 1 (RNA 1), RNA 1 entered Resident 33's room and stated the call light was clipped to the light string and was not within reach of the resident, but it should have been within reach so the resident could call and get assistance. RNA 1 unclipped the light from the light string and clipped the call light cord to the resident's sheet and placed the call light button near the resident's hand. During an interview on 1/31/2025 at 8:30 a.m., with the Director of Staff Development (DSD), the DSD stated every resident has a right to have a call light to call for assistance. The DSD stated when the call light is not within reach it could result in the resident trying to reach for the call light and potentially resulting in a fall. During a concurrent interview and record review on 1/31/2025 at 9:30 a.m., with the Director of Nursing (DON), the DON reviewed the facility policy and procedures regarding call lights. The DON stated the call light cord should be clipped to the bed sheet and not clipped to the string from the light. The DON stated staff should make sure the call light is not clipped or tangled with the light string to ensure the resident can call for assistance. The DON stated when the call light is not within reach of the resident it can potentially result in staff not attending to the resident and the resident not getting help during an emergency. The DON stated the facility policy was not followed when Resident 33's call light was not within reach. During a review of the facility's policy and procedure (P&P) titled, Answering the Call Lights, last reviewed 1/22/2025, the P&P indicated the purpose of the policy was to ensure timely responses to the resident's requests and needs. Ensure the CL is accessible to the resident when in bed. During a review of the facility P&P titled, Resident Rights, last reviewed 1/22/2025, the P&P indicated employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of the facility. These rights include the residents right to communication with and access to people and services, both inside and outside the facility. 43988 b. During a review of Resident 94's Admission Record, the Admission Record indicated the facility originally admitted the resident on 3/10/2023 and readmitted the resident into the facility on [DATE] with diagnoses including type two (2) diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN - high blood pressure), and generalized muscle weakness. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 94's MDS, dated [DATE], the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required setup or clean-up assistance with eating; supervision or touching assistance with oral hygiene; partial/moderate assistance to substantial/maximal to total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 94's H&P dated 12/20/2024, the H&P indicated Resident 94 had the capacity to understand and make decisions. During a review of Resident 94's care plan on risk for falls initiated on 12/17/2024, the care plan indicated to place the call light within reach while in bed or close proximity to the bed as one of the interventions to prevent falls. During a review of Resident 94's fall risk evaluation form dated 12/17/2024 and 1/26/2025, the fall risk evaluations indicated Resident 94 was a risk for falls. During a concurrent observation and interview on 1/28/2025 at 9:52 a.m., while inside Resident 94's room with Licensed Vocational Nurse 3 (LVN 3), LVN 3 verified Resident 94's call light was on the floor. LVN 3 stated staff should ensure the call light was within the resident's reach prior to leaving the room so the resident can call for assistance. LVN 3 stated Resident 94's call light should have been within reach at all times so the resident would be able to call for assistance when needed. n LVN 3 stated if the call light was not within reach, Resident 94 would not be able to ask for assistance and the resident might get out of bed unassisted and fall. During an interview on 1/30/2025 at 2:30 p.m. with the DON, the DON stated the staff should place the call light within the residents' reach prior to leaving the room to ensure the residents can call for assistance and for the staff to meet their needs. The DON stated Resident 94's call light should have been within reach to ensure the resident would be able to call for assistance to prevent delay in the provision of care the resident needs, which may lead to Resident 94 getting out of bed unassisted and possibly fall. During a review of the facility's P&P titled, Answering the Call Light, last reviewed on 1/25/2025, the P&P indicated to ensure that the call light is accessible to the resident when in bed for timely response to the resident's requests and needs.

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44244 Based on interview and record review, the facility failed to provide in writing the completed Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN - a notification to the resident or responsible party [RP] of the potential liability charges for services not covered when the resident was discharged from Medicare Part A services with benefit days remaining) and the Notice of Medicare Non-Coverage (NOMNC - a notification to inform the resident or RP of the pending termination of coverage and of his/her right to an expedited review of service determination) for two of three sampled residents (Residents 13 and 118) reviewed during the Beneficiary Notification task. This deficient practice had the potential to result in residents or RPs not being able to exercise their rights to be informed in advance of financial responsibilities, request an expedited review upon appeal, or determine in advance the course of their care. Findings: a. During a review of Resident 118's Admission Record, the Admission Record indicated the facility admitted the resident on 12/10/2024 with diagnoses that included urinary tract infection (UTI - an infection in the bladder/urinary tract), pneumonia (an infection/inflammation in the lungs), muscle weakness, and benign prostatic hyperplasia (BPH - enlargement of the prostate gland that may result in urinary retention). During a review of Resident 118's Minimum Data Set (MDS - resident assessment tool), dated 12/16/2024, the MDS indicated the resident was able to understand others and was able to make himself understood. During a review of Resident 118's History and Physical Examination form, dated 12/16/2024, the History and Physical Examination form indicated the resident had the capacity to understand and make decision. During a review of Resident 118's SNF Beneficiary Protection Notification Review form, the SNF Beneficiary Protection Notification Review form indicated the facility initiated the discharge from Medicare Part A services when benefit days were not exhausted. The document indicated that the last covered day of Medicare Part A service was 1/31/2025. During a review of Resident 118's NOMNC form, signed by the Business Office Assistant (BOA) on 1/28/2025, the NOMNC form indicated the BOA notified Resident 118's RP via telephone that services will end and the RP may appeal the decision. The NOMNC form did not indicate Resident 118 or the resident's RP signed the form. During a review of Resident 118's SNF ABN form, signed by the BOA on 1/28/2025, the SNF ABN form indicated Resident 118's RP was notified via telephone that the services provided did not meet the Medicare Part A coverage requirements. The SNF ABN form did not indicate an estimated out of pocket share of cost. The SNF ABN form did not indicate Resident 118 or the resident's RP signed the form. (continued on next page)

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	During a concurrent interview and record review, on 1/30/2025, at 11:00 a.m., with the BOA, Resident 118's SNF ABN form, dated 1/28/2025, and NOMNC form, dated 1/28/2025, were reviewed. The BOA stated the facility's previous Business Office Manager (BOM) completed the SNF ABN and NOMNC, but the BOM left a few weeks ago and now the BOA was completing the forms. The BOA stated the forms are provided to residents or their RP before the last day of Medicare Part A coverage to notify the resident that they will be responsible for paying their share of costs and the resident has a right to appeal. The BOA stated the BOA called Resident 118's RP regarding the notification forms and did not provide the written forms to the resident or RP. The BOA stated he was not aware the notification forms should be provided in writing to the RP because he just took over providing the notification forms when the BOM left the facility. The BOA stated Resident 118's SNF ABN form was not complete because it did not include an estimated share of cost and there was no documented evidence that the RP was notified of the estimated share of cost. The BOA stated it was important for a resident or RP to know their estimated share of costs because they may mistakenly believe their insurance will cover the total amount. The BOA stated when residents or RPs are not informed it may result in the resident or RP not being able to make informed decisions regarding their care. The BOA stated he was not aware the SNF ABN and NOMNC should be provided in writing and that the SNF ABN should indicate the estimated share of costs because he was new to completing the forms. During a follow up concurrent interview and record review, on 1/30/2025, at 11:45 a.m., with the BOA, the facility's policy and procedure (P&P) titled, Medicare Advanced Beneficiary Notice, last reviewed 1/22/2025, was reviewed. The BOA stated the P&P indicated that the SNF ABN and NOMNC must be completed and provided in writing. The BOA stated the facility's P&P was not followed. During a concurrent interview and record review, on 1/31/2025, at 10:01 a.m., with the Administrator (ADM), the facility's P&P titled, Medicare Advanced Beneficiary Notice, last reviewed 1/22/2025, was reviewed. The ADM stated the ADM was responsible for overseeing the business office after the BOM quit. The ADM stated the facility policy is the SNF ABN and NOMNC must be provided in writing to the resident or RP. The ADM stated the SNF ABN must include the share of cost to ensure the resident or RP has all the information regarding their right to appeal. The ADM stated the facility practice is to directly give the SNF ABN and NOMNC forms to the resident or RP and have them sign the forms. The ADM stated if the RP is not available, they may call the RP and send the written forms via certified mail with a request to return the signed the forms. The ADM stated she did not know the BOA was not aware of this practice and she was relying on the facilities consultants to educate the BOA when the BOM left the facility. The ADM stated the facility's policy was not followed when the BOA did not provide the completed forms in writing. During a review of the facility's P&P titled, Medicare Advanced Beneficiary Notice, last reviewed 1/22/2025, the P&P indicated residents are informed in advance when changes will occur to their bills. 1. If the director of admissions or benefits coordinator believes (upon admission or during the resident's stay) that Medicare (Part A of the Fee for Service Medicare Program) will not pay for an otherwise covered skilled services, the resident (representative) is notified in writing why the services may not be covered and of the resident's potential liability for payment of the non-covered services. (continued on next page)

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	a) The facility issues the Skilled Nursing Facility Advanced Beneficiary Notice (CMS form 10055) to the resident prior to providing care that Medicare usually covers but may not pay for because the care is considered not medically reasonable and necessary, or custodial. b) The resident (or representative) may choose to continue receiving the skilled services that may not be covered and assume financial responsibility. 2.If the resident's Medicare Part A benefits are terminating for coverage reasons, the director of admissions or benefits coordinator issues the Notice of Medicare Non-Coverage (CMS form 10123) to the resident at least two calendar days before Medicare covered services end (for coverage reasons). a) The Notice of Medicare Non-Coverage informs the resident of the pending termination of coverage and of his/her right to an expedited review of service determination. b) The Notice of Medicare Non-Coverage is not indicated when the resident's Medicare covered days are exhausted; nor is it used to notify the resident of potential liability for payment. b. During a review of Resident 13's Admission Record, the Admission Record indicated the facility admitted the resident on 12/4/2010 and readmitted the resident on 10/7/2024 with diagnoses that included essential (primary) hypertension (high blood pressure with an unknown cause), muscle weakness, dysphagia (difficulty swallowing), and Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 13's MDS, dated [DATE], the MDS indicated the resident rarely or never was able to understand others and rarely or never was able to make herself understood. During a review of Resident 13's History and Physical Examination form, dated 12/10/2024, the History and Physical form indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 13's SNF Beneficiary Protection Notification Review form, the form indicated the facility initiated the discharge from Medicare Part A services when benefit days were not exhausted. The SNF Beneficiary Protection Notification Review form indicated that the last covered day of Medicare Part A service was 12/6/2024. During a review of Resident 13's NOMNC form, signed by the BOM on 12/3/2024, the NOMNC form indicated Resident 13's RP was notified via telephone by the facility's BOM that the services will end and the RP may appeal the decision. The NOMNC form did not indicate the form was signed by the resident's RP. During a review of Resident 13's SNF ABN form, signed by the BOM on 12/3/2024, the SNF ABN form indicated Resident 13's RP was notified via telephone that the services provided did not meet the Medicare coverage requirements. The SNF ABN form did not indicate the estimated out of pocket share of cost. The SNF ABN form did not indicate a signature from the resident or the resident's RP. (continued on next page)

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	During a concurrent interview and record review, on 1/30/2025, at 11:00 a.m., with the BOA, Resident 13's SNF ABN form, dated 12/3/2024, and NOMNC form, dated 12/3/2024, were reviewed. The BOA stated the facility's previous BOM completed the SNF ABN and NOMNC forms, but the BOM quit the facility a few weeks prior. The BOA stated the forms are provided to residents or their RP before the last day of Medicare Part A coverage to notify the resident that they will be responsible for paying their share of costs and the resident has a right to appeal. The BOA stated the forms indicated the BOM called Resident 13's RP regarding the notifications. The BOA stated there was no documented evidence the notification forms were mailed or provided in writing to the resident or RP. The BOA stated Resident 13's SNF ABN form was not complete because it did not include an estimated share of cost and there was no documented evidence that the RP was notified of the estimated share of cost. The BOA stated it was important for a resident or RP to know their estimated share of costs because they may mistakenly believe their insurance will cover the total amount. The BOA stated when residents or RPs are not informed it may result in the resident or RP not being able to make informed decisions regarding their care. During a follow up concurrent interview and record review, on 1/30/2025, at 11:45 a.m., with the BOA, the facility's P&P titled, Medicare Advanced Beneficiary Notice, last reviewed 1/22/2025, was reviewed. The BOA stated the P&P indicated that the SNF ABN and NOMNC must be completed and provided in writing. The BOA stated the facility's P&P was not followed. During a concurrent interview and record review, on 1/31/2025, at 10:01 a.m., with the facility ADM, the facility's P&P titled, Medicare Advanced Beneficiary Notice, last reviewed 1/22/2025, was reviewed. The ADM stated the ADM was responsible for overseeing the business office after the BOM quit. The ADM stated the facility's policy is the SNF ABN and NOMNC must be provided in writing to the resident or RP. The ADM stated the SNF ABN must include the share of cost to ensure the resident or RP has all the information regarding their right to appeal. The ADM stated the facility practice is to directly give the SNF ABN and NOMNC forms to the resident or RP and have them sign the forms. The ADM stated if the RP is not available, they may call the RP and send the written forms via certified mail with a request to return the signed the forms. The ADM stated she did not know the BOA was not aware of this practice and she was relying on the facilities consultants to educate the BOA when the BOM left the facility. The ADM stated the facility policy was not followed when the BOA did not provide the completed forms in writing and was not followed when there was no documented evidence the previous BOM provided the completed forms in writing to the resident or RP. During a review of the facility's P&P titled, Medicare Advanced Beneficiary Notice, last reviewed 1/22/2025, the P&P indicated residents are informed in advance when changes will occur to their bills. 1. If the director of admissions or benefits coordinator believes (upon admission or during the resident's stay) that Medicare (Part A of the Fee for Service Medicare Program) will not pay for an otherwise covered skilled services, the resident (representative) is notified in writing why the services may not be covered and of the resident's potential liability for payment of the non-covered services. c) The facility issues the Skilled Nursing Facility Advanced Beneficiary Notice (CMS form 10055) to the resident prior to providing care that Medicare usually covers but may not pay for because the care is considered not medically reasonable and necessary, or custodial. (continued on next page)

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	d) The resident (or representative) may choose to continue receiving the skilled services that may not be covered and assume financial responsibility. 2.If the resident's Medicare Part A benefits are terminating for coverage reasons, the director of admissions or benefits coordinator issues the Notice of Medicare Non-Coverage (CMS form 10123) to the resident at least two calendar days before Medicare covered services end (for coverage reasons). c) The Notice of Medicare Non-Coverage informs the resident of the pending termination of coverage and of his/her right to an expedited review of service determination. d) The Notice of Medicare Non-Coverage is not indicated when the resident's Medicare covered days are exhausted; nor is it used to notify the resident of potential liability for payment.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 43988 Based on observation, interview, and record review, the facility failed to provide a safe, comfortable, and homelike environment for one of three sampled residents (Resident 10) investigated under the Environmental Task by failing to maintain the cleanliness of Resident 10's electric stand fan. This deficient practice has the potential to negatively affect the resident's quality of life. Findings: During a review of Resident 10's Admission Record, the Admission Record indicated the facility originally admitted the resident on 12/7/2022 and readmitted in the facility on 5/28/2024 with diagnoses including chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and generalized weakness. During a review of Resident 10's History and Physical (H&P) dated 5/29/2024, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 10's Minimum Data Set (MDS, a resident assessment tool), dated 9/9/2024, the MDS indicated the resident had an intact cognition (mental action or process of acquiring knowledge and understanding) and required setup or clean-p assistance with eating; supervision or touching assistance with personal hygiene; substantial/maximal assistance with upper body dressing and rolling left and right; total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a concurrent observation and interview on 1/28/2025 at 10:30 a.m., inside Resident 10's room, with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated the frame of the electric stand fan placed on the floor by the foot of Resident 10's bed had strips of gray powder-like material lining the outward front and back of the frame. LVN 2 stated the gray powde- like material on the fan is dust. LVN 2 stated housekeeping was responsible to clean any equipment or appliance in the facility. LVN 2 stated cleaning of furniture like electric fan is done during daily cleaning of the room. LVN 2 stated housekeeping staff should have checked any furniture in the room such as the electric fan daily when the room is cleaned and clean if visibly soiled to provide a safe and clean environment for the residents. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 1/28/2025 at 10:34 a.m., inside Resident 10's room with the Housekeeping Supervisor (HKS), the HKS verified Resident 10's electric fan had strips of gray powder-like material on the back and front frame and described it as dust. The HKS stated housekeeping department is responsible to ensure cleanliness of furniture such as electric fans. The HKS stated furniture in the room including electric fan are cleaned on a regular basis when the room is scheduled for deep cleaning monthly. The HKS stated housekeeping staff are supposed to check the fans every day and clean if with dust. The HKS stated the staff should have cleaned the electric fan every day to prevent buildup of dust for resident safety and to keep the resident environment clean. The HKS stated if the fan was not clean then the air coming out was not clean as well and can be a source of infection. During an interview on 1/28/2025 at 3:02 p.m. with the Director of Nursing (DON), the DON stated the housekeeping department is primarily responsible to maintain cleanliness of any furniture inside the resident room. The DON stated the housekeeping department has a monthly schedule of rooms for deep cleaning which include cleaning the furnishings such as fans. The DON stated if cleanliness is not maintained such as heavy dust in an electrical fan can cause allergens due to unclean air coming from the fan. The DON stated it was also not providing a homelike environment, thus affecting resident's quality of life. During a review of the facility's P&P titled, Homelike Environment, last reviewed 1/25/2025, the P&P indicated residents are provided with a safe, clean, comfortable, and homelike environment. The policy indicated the staff, and management maximizes the characteristics of the facility that reflect a personalized, homelike setting by providing a clean, sanitary, and orderly environment.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity including the right to be free from physical restraints (any manual method, physical or mechanical device, equipment, or material that is attached or adjacent to the resident's body, cannot be removed easily by the resident, and restricts the resident's freedom of movement or normal access to his/her body) for one (1) of one sampled resident (Resident 95) investigated during a review of the physical restraints care area when the facility failed to obtain a physician's order, perform an assessment, obtain an informed consent (process in which residents or resident representatives are given important information, including possible risks and benefits, about a procedure or treatment), and develop a care plan for the use of pillows tucked underneath the fitted sheet. These deficient practices had the potential to result in the restriction of the residents' freedom of movement, a decline in physical functioning, psychosocial harm, physical harm from entrapment (a state in which a person is trapped by the bed rail in a position that they cannot move from), and death of residents. Findings: During a review of Resident 95's Admission Record, the Admission Record indicated the facility admitted the resident into the facility on [DATE] with diagnoses including Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), hypertension (HTN - high blood pressure), and atrial fibrillation (an irregular and often very rapid heart rhythm which can lead to blood clots in the heart). During a review of Resident 95's fall risk evaluation dated 12/3/2024, the fall risk evaluation indicated the resident was a high risk for falls. During a review of Resident 95's History and Physical (H&P) dated 12/8/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 95's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 12/10/2024, the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required substantial/maximal assistance with eating, upper body dressing, and rolling left and right; total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS did not indicate Resident 95 had a restraint. During a review of Resident 95's care plan (CP) for the risk for falls due to attempts to get out of bed without assistance initiated on 12/10/2024 and last revised on 12/23/2024, the CP indicated to conduct frequent visual checks for safety as one of the interventions to prevent falls. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 1/28/2025 at 10:27 a.m. while inside Resident 95's room, Resident 95 was observed lying in bed, alert, and answers with mumbling sounds. The pillows were tucked under Resident 95's fitted sheet on both sides of the bed and the resident appeared sunk in the bed. During a concurrent observation and interview on 1/28/2025 at 10:43 a.m., while inside Resident 95's room with Certified Nursing Assistant 1 (CNA 1), CNA 1 verified the pillows were tucked under the fitted sheet on both sides of the bed to prevent Resident 95 from falling as the resident gets out of bed unassisted. CNA 1 stated the staff have always used the pillows tucked under the fitted sheet. CNA 1 stated placing the pillows under the fitted sheets restricts Resident 95's movement. During an interview on 1/30/2025 with the Director of Staff Development (DSD), the DSD stated placing pillows tucked under the fitted sheet on both sides of the bed is not acceptable and is a form of restraint and it restricts the resident's movement. The DSD stated CNA 1 should not have placed the pillows under the fitted sheet to prevent Resident 95 from falling if the resident gets out of bed unassisted. During an interview on 1/30/2025 at 2:30 p.m. with the Director of Nursing (DON), the DON stated pillows tucked under the fitted sheet is not allowed to prevent the residents from falling. The DON stated if the pillows under the fitted sheet is a family preference, the licensed nurse is supposed to obtain an order from the physician, obtain informed consent so the family would be aware of the risks and consequences of placing the pillows under the fitted sheet, complete a restraint assessment to ensure the use of the restraint is appropriate, and develop and implement a care plan so the staff would be aware of the proper interventions to care for the resident. The DON stated the pillows tucked under the fitted should not have been placed on Resident 95 as the pillows restrict Resident 95's freedom of movement and is considered a restraint. During a review of the facility's policy and procedure (P&P) titled, Use of Restraints, last reviewed on 1/125/2025, the P&P indicated: - Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried successfully. - Restraints shall only be used to treat the resident's medical symptoms and never for discipline or staff convenience or for the prevention of falls. - Physical restraints are defined at any manual method, or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. - If the resident cannot remove a device in the same manner in which the staff applied it given the resident's physical condition and this restricts his/her typical ability to change position or place, that device is considered a restraint. - Prior to placing a resident in restraints, there shall be pre-restraining assessment, and review to determine the need for restraints. The assessment shall be used to determine the possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions that may improve the symptoms (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Restraints shall only be used upon the written order of the physician and after obtaining consent from the resident and/or representative. The order shall include the following: a. The specific reason for the restraint. b. How the restraint will be used to benefit the resident's medical symptom. c. The type of restraint, and period of time for the use of the restraint. - Residents and/or surrogate/sponsor shall be informed about the potential risks and benefits of all options under consideration, including the use of restraints, not using restraints, and the alternatives to restraint use - Care plans for residents in restraints will reflect interventions that address not only the immediate medical symptom (s) but the underlying problems that may be causing the symptom(s) - Care plans shall also include the measures taken to systematically reduce or eliminate the needs for restraint use

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on interview and record review, the facility failed to accurately complete the admission diagnosis and the minimum data set (MDS - a comprehensive resident assessment tool) assessment Section I (active diagnoses) on 12/13/2024 for one (1) of four (4) residents (Resident 21) sampled for unnecessary medications by omitting a diagnosis of schizophrenia (a mental zdisorder characterized by disordered thinking, behaviors, and emotions that impairs daily functioning) and bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration, making it difficult to carry out day-to-day tasks.) This deficient practice increased the risk that Resident 21 may not have received care planning and treatment according to Resident 21's needs possibly leading to a decline in Resident 21's overall health and well-being. Findings: During a review of Resident 21's Admission Record (a document containing demographic and diagnostic information), the Admission Record indicated Resident 21 was originally admitted to the facility on [DATE] with a diagnosis including bipolar disorder. The Admission Record did not indicate a diagnosis including schizophrenia or depression. During a review of Resident 21's General Acute Care Hospital (GACH) 1 records, dated 11/24/2024, the GACH 1 records indicated Resident 21 had history of bipolar disorder and schizophrenia. The records did not indicate a history of depression. Resident 21 was taking quetiapine (an antipsychotic [against psychosis {severe mental disorder that causes abnormal thinking and perception}] medication that treats several kinds of mental health conditions including schizophrenia) and sertraline (an antidepressant [against depression] medication used for depression or bipolar disorder) for bipolar/schizophrenia as follows: 1. quetiapine 50 milligram (mg - a unit of measure of mass) one (1) tablet by mouth twice a day 2. quetiapine 25 mg one (1) tablet by mouth daily at noon 3. sertraline 50 mg one (1) tablet by mouth daily During a review of Resident 21's History and Physical (H&P - a record of a comprehensive physician's assessment), by Medical Doctor (MD) 1, dated 12/5/2024, indicated a diagnosis of bipolar disorder and schizophrenia and did not indicate a diagnosis of depression. During a review of Resident 21's MDS, dated [DATE], the MDS indicated Resident 21 was cognitively (mental action or process of acquiring knowledge and understanding) intact. Resident 21's MDS indicated zero (0) symptoms of having Little interest or pleasure in doing things and zero (0) symptoms in Feeling down, depressed, or hopeless. Resident 21's MDS indicated a diagnosis for bipolar disorder, and did not indicate a diagnosis for depression and schizophrenia. Resident 21's MDS indicated Resident 21 was taking antipsychotics and antidepressants. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	During a review of Resident 21's Medication Administration Record (MAR - a record of mediations administered to residents), dated January 2025, the MAR indicated Resident 21 was prescribed the following: 1. quetiapine 25 mg one (1) tablet by mouth once a day for schizophrenia manifested by screaming for no apparent reason at 9 a.m., starting 12/7/2024 2. sertraline 50 mg one (1) tablet by mouth daily for depression manifested by sadness at 9 a.m., starting 12/7/2024 During a concurrent interview and record review, on 1/30/2025, at 2:12 p.m., with the Director of Nursing (DON), Resident 21's GACH records, dated 11/24/2024, Admission Record, MDS, dated [DATE], and MAR, dated 1/2025, were reviewed. The DON stated the DON along with the MDS coordinator completes the MDS assessments. The DON stated Resident 21's GACH records indicated Resident 21 had a medical history of bipolar disorder and schizophrenia, and the facility admission diagnosis indicated bipolar disorder, while the MDS assessment indicated diagnoses of schizophrenia and depression. The DON stated it was important for the admission and MDS assessment to accurately reflect the needs of Resident 21 to ensure the facility maintained the highest level of functionality and quality of life for Resident 21. The DON stated the facility did not include accurate diagnoses for Resident 21 on Resident 21's Admission Record and MDS Section I assessment, initiated on 12/13/2024, because it was missed and overlooked. During a review of the facility's policy and procedures (P&P) titled, Resident Assessments, last reviewed 1/22/2025, the P&P indicated: 6. The Resident Assessment Coordinator is responsible for ensuring that the Interdisciplinary Team (IDT) conducts timely and appropriate resident assessments. 12. Information in the MDS assessments will consistently reflect information in the progress notes, plans of care . During a review of the facility's P&P titled, Psychotropic Medication Use, last reviewed 1/22/2025, the P&P indicated: Residents will not receive medications that are not clinically indicated to treat a specific condition. 1. A psychotropic medication is any medication that affects brain activity associated with mental processes and behavior. 2. Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: a. Anti-psychotic b. Anti-depressants 8. Consideration of the use of any psychotropic medication is based on comprehensive review of the resident. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	3. When determining to initiate .medication therapy, the IDT conducts an evaluation of the resident. The evaluation will attempt to clarify whether: a. Signs and symptoms are clinically significant enough to warrant medication therapy b. A particular medication is clinically indicated to manage the symptoms or condition.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 38552 Based on interview and record review, the facility failed to ensure residents are screened using the Preadmission Screening and Resident Review (PASRR, a federal requirement to help ensure that individuals are not appropriately placed in nursing homes for long-term care) for a mental disorder (MD) or intellectual disability (ID) prior to admission and that individuals identified with serious mental illness (SMI) and/or ID/developmental disability (DD)/related conditions (RC) receive the care and services in maintaining his/her highest practicable level in the most appropriate setting for one of five sampled residents (Resident 48) investigated under PASRR care area, by failing to submit a new Level 1 PASRR for Resident 48, who had a discrepancy in the previous PASRR Level I screening and ensure it was completed accurately. This deficient practice had the potential to result in inappropriate placement and unidentified specialized services for Resident 48. Findings: During a review of Resident 48's Admission Record, the Admission Record indicated the facility originally admitted the resident on 8/10/2022 with diagnoses including bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), calculus (small, hard deposits made of minerals and salts) of kidney (also called kidney stones), and neoplasm (a new and abnormal growth of tissue in some part of the body) of uncertain behavior of skin. During a review of Resident 48's General Acute Care Hospital 2 (GACH 2)'s Physician Progress Notes, dated 8/4/2022, GACH 2's Physician Progress Notes indicated the psychiatry evaluation for the resident to rule out schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) or bipolar mania. During a review of Resident 48's GACH 2's Discharge Medication Reconciliation Order Report, dated 8/9/2022, GACH 2's Discharge Medication Reconciliation Order Report indicated the following: - Olanzapine (antipsychotic-drug used to manage abnormal condition of the mind described as involved a loss of contact with reality) 7.5 milligram (mg-a unit of measurement) orally every day at bedtime for psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 48's Psychiatry Progress Note, dated 8/21/2022, the Psychiatry Progress Note indicated the resident has bipolar disorder and schizoaffective disorder. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 48's Minimum Data Set (MDS-a resident assessment tool), dated 11/10/2024, the MDS indicated the resident had the ability to make self understood and understand others. The MDS indicated the resident was dependent on staff for toileting hygiene, shower/bathe self, lower body dressing, and putting on/taking off footwear. The MDS indicated the resident required assistance with mobility from staff including roll left and right, sit to lying, lying to sitting on side of bed, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer. The MDS indicated the resident was taking antipsychotic and anticonvulsant medications under high-risk drug classes. During a concurrent interview and record review on 1/30/2025 at 9:19 a.m. with the Assistant Director of Nursing (ADON), Resident 48's PASRR dated 8/10/2022 was reviewed. The PASRR indicated negative for level 1. The ADON stated it (PASRR) should have been coded yes when Resident 48 had diagnosed of mental disorder and should have been yes when resident was prescribed medications for mental illness. During an interview on 1/31/2025 at 4:39 p.m. with the Director of Nursing (DON), the DON stated Resident 48's PASRR first diagnoses and medication resulted in level 1 positive. The DON stated if a resident had any mental changes, they would need to submit a new PASRR screening. The DON stated they had to ensure that the completed PASRR was correct and appropriate. The DON stated when PASRRs are not completed accurately it could potentially place the residents for missed opportunities and services. During a review of the facility's policy and procedure (P&P) titled, PASRR Completion Policy, last reviewed and approved on 1/22/2025, the P&P indicated the facility will make sure that all admissions have the appropriate PASRR completed. The P&P indicated the designated staff will ensure that the PASRR is done and completed.

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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** 44244 Based on observation, interview and record review, the facility failed to develop a comprehensive person-centered care plan (CP-a document outlining a detailed approach to care customized to an individual resident's needs) by failing to: 1. Develop and implement a care plan for Resident 145's use of side rails (SR or bed rail, adjustable rigid plastic or metal bars attached to the bed that may be positioned in various locations on the bed; upper or lower, either or both sides) for one of five sampled residents reviewed under the Accidents care area. This deficient practice had the potential to result in a delay in the provision of necessary care and services for residents using SRs. 2. Implement the care plan intervention to monitor the side effects (also known as adverse effects - unwanted, uncomfortable, or dangerous effects that a drug may have) of Pradaxa (an anticoagulant [blood thinner] medication used for atrial fibrillation [Afib - a condition with irregular, fast heart rate caused by poor blood flow]), for one of four residents reviewed for unnecessary medications (Resident 141). As a result, Resident 141 was not monitored for the side effects for the use of Pradaxa between 1/1/2025 and 1/30/2025. This deficient practice had the potential to result in Resident 141 receiving suboptimal (less than the highest standard or quality) care leading to the use of unnecessary medications causing potential side effects (unwanted, unpleasant results of a medication) and negatively impacting their physical, mental, and psychosocial well-being. 3. Develop and implement a care plan for Resident 147's refusals of physical therapy treatments. This deficient practice had the potential to result in Resident 147's decline in mobility, strength, and overall physical function, leading to increased dependence to providers. 4. Develop and implement a care plan for Resident 86's use of a low air loss mattress (LALM-a pressure reducing support surface). This deficient practice had the potential to result in not addressing Resident 86's needs, preferences, and necessary adjustments to mattress settings leading to discomfort or complications. Cross reference F700 (Resident 145) Findings: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. During a review of Resident 145's Admission Record, the Admission Record indicated the facility admitted the resident on 10/23/2024 and readmitted the resident on 11/23/2024 with diagnoses that included spinal stenosis (a narrowing of the spinal canal in your lower back that may cause pain or numbness in your legs), radiculopathy (a condition that occurs when a nerve in the spine is damaged or irritated, often called a pinched nerve), cervical region (area at the neck), lack of coordination, and muscle weakness. During a review of Resident 145's Order Summary Report, the report indicated an order for bed rails as enabler for turning and repositioning in bed, dated 11/23/2024. During a review of Resident 145's Minimum Data Set (MDS - resident assessment tool) dated 11/29/2024, the MDS indicated the resident was able to understand others and was able to make herself understood. The MDS further indicated the resident had an impairment on one side of the upper extremities, was dependent on staff for toileting and bathing, and required partial/moderate assistance for personal and oral hygiene. The MDS indicated the resident required substantial/maximal assistance from staff for transferring from the bed to chair, rolling left to right in the bed, and moving from sitting to lying. During a concurrent observation and interview on 1/28/2025 at 8:45 a.m., Resident 145 lay in bed with bilateral (both sides) upper siderails in the raised position. Resident 145 stated the siderails are always up. During a concurrent observation, interview, and record review on 1/30/2025 at 8:45 a.m. with Minimum Data Set Nurse 1 (MDSN 1) and Registered Nurse 1 (RN 1), MDSN 1 and RN 1 reviewed Resident 145's physician orders and care plans. MDSN 1 entered Resident 145's room and stated the resident had bilateral upper siderails in use. RN 1 stated Care Plans are used to provide a resident's care with resident specific interventions and goals. RN 1 stated resident's using SRs should have a CP for the use of SRs. RN 1 stated the importance of the siderail care plan was to know if resident goals, like remaining free of injury from the use of siderails, were met or not met. RN 1 stated Resident 145 did not have a care plan for the use of siderails but should have. During an interview on 1/31/2025 at 9:30 a.m. with the Director of Nursing (DON), the DON stated resident centered care plans specify resident's specific needs and problems. The DON stated care plans are followed for each resident to deliver the right intervention for the resident. The DON stated the facility policy was not followed when Resident 145 did not have a care plan for the use of siderails. During a review of the facility Policy and Procedure (P&P) titled, Siderails, last reviewed 1/22/2025, the P&P indicated the purpose of the policy was to ensure the safe use of side rails as an assistive device, to aid mobility, or to treat medical symptoms. The LN will complete the Bedrail Evaluation and develop a Care Plan reflecting the evaluation. During a review of the facility's P&P titled, Care Plan Comprehensive, last reviewed 1/22/2025, the P&P indicated an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, physical, mental and psychosocial needs shall be developed for each resident. The facility's IDT, in coordination with the resident and/or his/her family or representative, must develop and implement a comprehensive person-centered care plan for each resident. Each resident ' s comprehensive care plan is designed to: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Incorporate identified problem areas. b. Incorporate risk and contributing factors associated with identified problems. c. Build on the resident's individualized needs, strengths, preferences . f. Reflect treatment goals, timetables, and objectives in measurable outcomes . The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS). Assessments of resident's are ongoing and care plans arc reviewed and revised as information about the resident and the resident 's condition change. 43455 b. During a review of Resident 141's Admission Record (a document containing demographic and diagnostic information,) dated 1/30/2025, the Admission Record indicated Resident 141 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including Afib. During a review of Resident 141's Order Summary Report, dated 8/22/24, the report indicated Resident 141 was prescribed Pradaxa 150 milligram ([mg] - a unit of measure of mass) one tablet by mouth every 12 hours for Afib., starting 12/18/2024. During a review of Resident 141's Care Plan, initiated 12/31/2024, the Care Plan indicated: Resident is at risk for injury or complications related to the use of anticoagulation therapy medication Pradaxa. Observe for active bleeding, i.e. hematuria, bruising, guaiac+ (bloody) stool, nose bleeds, bleeding gums, etc. During a review of Resident 141's Medication Administration Record ([MAR] - a record of mediations administered to residents,) for January 2025, the MAR indicated Resident 141 was prescribed Pradaxa 150 mg one tablet by mouth every 12 hours for Afib., at 9 a.m. and 9 p.m. The MAR did not contain documentation for the monitoring of side effects of Pradaxa between 1/1/2025 and 1/30/2025. During a concurrent record review and interview on 1/30/2025 at 10:08 a.m., with the DON, the DON stated that Resident 141's Care Plan dated 12/31/2024 indicated Resident 141 was at risk of complications from Pradaxa, and to monitor for active bleeding. The DON stated monitoring for bleeding would be documented on the MAR, and that the DON was unable to locate documentation for monitoring for bleeding related to the use of Pradaxa for Resident 141 between 1/1/2025 and 1/30/2025. The DON stated that monitoring for bleeding with Pradaxa use was important to ensure Resident 141 does not have bleeding that was unnoticed, which may harm the resident and require hospitalization . The DON stated the facility failed to implement the Care Plan to accurately reflect the needs of Resident 141 and ensure to maintain the highest level of functionality and quality of life, with measurable goals and outcomes for Afib with the use of Pradaxa. The DON stated that monitoring for anticoagulation therapy with Pradaxa will be immediately implemented for Resident 141. A review of the facility's Policy & Procedures (P&P,) titled Care Plan Comprehensive, last reviewed 1/22/2025, the P&P indicated that An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, physical, mental and psychosocial needs shall be developed for each resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Each resident's comprehensive care plan is designed to: c. Build on the resident's individualized needs, strengths, preferences. f. Reflect treatment goals, timetables, and objectives in measurable outcomes. 2. The comprehensive care plan includes the following: a. The services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being. A Review of the facility's P&P titled Medication Regimen Review, last reviewed 1/22/2025, the policy indicated: 5. The Medication Regimen Review involves a thorough review of the resident's medical record to prevent, identify, report and resolve medication related problems, medication errors and other irregularities, for example: d. inadequate monitoring for adverse consequences 9. An irregularity refers to the use of medication .without adequate monitoring .and or in the presence of adverse consequences. 38552 c. During a review of Resident 147's Admission Record, the Admission Record indicated the facility admitted the resident on 11/29/2024 with diagnoses including nondisplaced intertrochanteric fracture (break-in bone) of the right femur (thigh bone), orthopedic aftercare (follow-up care and treatment after surgery or an injury to bones or joints), and rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility). During a review of Resident 147's History and Physical, dated 12/1/2024, the History and Physical indicated the resident had a plan for rehabilitation and has good rehab potential. During a review of Resident 147's Order Summary Report, the summary report indicated the following: - Physical Therapy (PT) - Evaluation and Treatment as recommended, dated 11/29/2024. - PT clarification of treatment for therapeutic exercises, neuromuscular reeducation, therapeutic activities, and gait training daily for five (5) days per week for 30 days, dated 11/30/2024. - Continue PT treatment for therapeutic exercises, neuromuscular reeducation, therapeutic activities, gait training daily for 5 days per week for 30 days, dated 12/30/2024. (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 review of Resident 147's MDS, dated [DATE], the MDS indicated the resident had the ability to make self understood and understand others. The MDS indicated the resident had an impairment on one side on the lower extremity that interfered with daily functions or placed the resident at risk of injury. The MDS indicated the resident required maximal assistance with the ability to roll left and right, sit to lying, lying to sitting on one side of bed, sit to stand, chair/bed-to-chair transfer. During an observation on 1/30/2025 at 3:10 p.m., at Resident 147's bedside, with Physical Therapist 1 (PT 1), PT 1 asked the resident if they could change the sheet so they could roll her to the right, but the resident refused to move. PT 1 asked the resident to change her position from lying to sitting on the side of the bed. PT 1 assisted the resident to sitting in the side of bed position. Resident 147 stated she wants to lie back down in the bed. Resident 147 refused to continued physical therapy treatment. During a concurrent interview and record review on 1/31/2025 at 2:32 p.m., with PT 1, Resident 147's Missed Visit Details, were reviewed and indicated the following: - 12/12/2024 -refused treatment even with max encouragement. - 12/13/2024 - refused treatment family present and unable to encourage resident to participate in therapy. - 12/16/2024 - refused treatment. - 12/17/2024 - refused treatment. - 1/10/2025, refused treatment multiple attempts and max encouragement. PT 1 stated Resident 147's missed visit details were reported to the Director of Rehabilitation (DOR) and informed that they were having issues with the resident. PT 1 stated the DOR will then involve social services and the interdisciplinary team members. During a concurrent interview and record review on 1/31/2025 at 1:55 p.m., with the Social Services Assistant 1 (SSA 1), Resident 147's Social Services Assessment and Documentation dated 12/3/2024 was reviewed. SSA 1 stated they discussed with the rehab team the resident's progress in the minutes, but it is not documented in the resident's progress notes. SSA 1 stated 12/3/2024 was the last contact she had with the resident's RP. During an interview on 1/31/2025 at 2:42 p.m., PT 1 stated Resident 86 required maximum encouragement including talking to the resident and explaining what they are going to do; approach more than once or keep trying; explain to the resident while providing the care/treatment; continually encourage resident to participate; try different approaches such as with rolling left and right and bed they can ask the resident would they like their sheet changed. PT 1 stated the potential outcome for the resident for multiple missed visit details would be stiffness, atrophy of the legs, loss of muscle strength, loss of sitting balance and tolerance, and at risk for skin breakdown if the resident is in bed all the time. PT 1 stated the care plan should be revised to reflect the updated goal. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 86's MDS, dated [DATE], the MDS indicated the resident had the ability to understand others and had the ability to make self understood. The MDS indicated the resident required moderate assistance with rolling left and right on the bed and required maximal assistance with lying to sitting on the side of bed and with no back support. The MDS indicated the resident used a pressure reducing device for bed. During an observation on 1/28/2025 at 9:21 a.m., while at Resident 86's bedside, Resident 86 was lying in bed with LALM settings at 400 pounds (lbs - a unit of measurement). During a concurrent observation and interview on 1/31/2025 at 11:45 a.m., while at Resident 86's bedside, Resident 86 was lying in bed with LALM settings at 350 lbs. with the red light on low pressure. Certified Nursing Assistant 4 (CNA 4) stated the resident's LALM will alarm every 15 minutes (min-a unit of measurement) so he sets the LALM settings beyond the resident's weight. CNA 4 stated he can adjust the weight settings up or down, usually sets it at maximum, but set it at 350 lbs today. CNA 4 stated if he sets it at 150 lbs of the resident's weight the LALM will alarm. CNA 4 stated this has been going on for about 3 months now and has informed the previous charge nurse but has not informed Licensed Vocational Nurse 5 (LVN 5) today. CNA 4 stated yes CNAs can adjust the LALM settings. During an interview on 1/31/2025 at 11:53 a.m., with LVN 5, LVN 5 stated he was not aware of Resident 86's LALM not working. LVN 5 stated only the treatment nurse can adjust the resident's mattress settings. During a concurrent interview and record review on 1/31/2025 at 12 p.m. with Registered Nurse 2 (RN 2), Resident 86's physician orders was reviewed. RN 2 stated there was no order for the use of the LALM. RN 2 stated there should be an order for the use of the LALM as part of the monitoring and treatment for the resident. During a concurrent interview and record review on 1/31/2025 at 12:03 p.m. with RN 2, Resident 86's care plans were reviewed. RN 2 stated there was no care plan developed for the use of the LALM. During an interview on 1/31/2025 at 4:41 p.m., with the DON, the DON stated LALM are for residents who have multiple pressure ulcers or have a high risk for development of pressure ulcers. All residents have a pressure reducing mattress which is pressure reliving and can have it to help to prevent the resident from developing pressure ulcers. The DON stated the use of LALM needs to have settings in place and the treatment nurse would place a sticker on the machine indicating what the setting is, this way everyone would know. The DON stated there would be an order and it would be monitored in the electronic medical administration record. The DON stated CNAs cannot manipulate the LALM settings and they should report the issue to their charge nurse or treatment nurse. The DON stated the LALM is for prevention and a care plan should be developed. The DON stated the resident could potentially be at risk for a pressure ulcer when care plan interventions are not implemented correctly. During a review of the facility P&P titled, Care Plan Comprehensive, last reviewed 1/22/2025, the P&P indicated an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, physical, mental and psychosocial needs shall be developed for each resident. The facility's IDT, in coordination with the resident and/or his/her family or representative, must develop and implement a comprehensive person-centered care for each resident. Each resident's comprehensive care plan is designed to: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Incorporate identified problem areas. b. Incorporate risk and contributing factors associated with identified problems. c. Build on the resident's individualized needs, strengths, preferences . f. Reflect treatment goals, timetables, and objectives in measurable outcomes . The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS). Assessments of resident's are ongoing and care plans arc reviewed and revised as information about the resident and the resident 's condition change.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 44244 Based on interview and record review the facility failed to ensure resident comprehensive care plans (CP - a written course of action that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs) regarding smoking were updated after a change of condition for one of five sampled residents (Resident 62) reviewed under the Accidents care area. This deficient practice had the potential to result in miscommunication among interdisciplinary staff, residents, and resident representatives regarding the resident's care needs. Findings: During a review of Resident 62's Admission Record, the Admission Record indicated the facility admitted the resident on 5/27/2019 and readmitted the resident on 1/4/2025 with diagnoses that included seizures (abnormal electrical activity in the brain), difficulty walking, and muscle weakness. During a review of Resident 62's Minimum Data Set (MDS - resident assessment tool), dated 1/9/2025, the MDS indicated the resident was able to understand others and was able to make himself understood. The MDS further indicated the resident required supervision or touching assistance with oral hygiene, toileting, dressing, and personal hygiene. The MDS indicated the resident had one fall since admission or readmission. During a review of Resident 62's History and Physical (H&P), undated, the H&P indicated the resident ambulated with walker and had the capacity to understand and make decisions. During a review of Resident 62's Change of Condition (COC) Evaluation, dated 1/5/2025, the COC indicated the resident fell and was found on his right side on the floor of the outside patio. During a review of Resident 62's Smoking Evaluation, dated 1/6/2025, the evaluation indicated the resident required supervision while smoking due to being a fall risk. During a review of Resident 62's Care Plan (CP) titled, Patient may smoke independently per smoking assessment ., initiated on 1/7/2025 and last revised on 1/28/2025, the CP indicated a goal that the resident would smoke safely. The CP indicated to reassess the resident's ability to smoke independently with any change of condition. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 1/28/2025, at 8:45 a.m., with the Assistant Director of Nursing (ADON), Resident 62's CPs and Smoking Evaluation, dated 1/6/2025, were reviewed. The ADON stated CPs are a tool used by all departments to know the plan of care for a resident. The ADON stated CPs are developed at admission and when a resident has a change of condition, like a fall. The ADON stated Resident 62 had a fall on the patio and a smoking evaluation was completed that indicated the resident should be supervised while smoking. The ADON stated Resident 62's CP regarding smoking indicated the resident may smoke independently. The ADON stated Resident 62's smoking CP was not updated to indicate the resident required supervision while smoking, but it should have been. The ADON stated when Resident 62's CP was not updated and revised it could have resulted in the resident not being supervised while smoking and potentially leading to injury from falls and burns. During a concurrent interview and record review, on 1/31/2025, at 9:30 a.m., with the Director of Nursing (DON), the facility's policy and procedures (P&P) titled Care Plan Comprehensive, last reviewed 1/22/2025, and Smoking, last reviewed 1/22/2025, were reviewed. The DON stated CPs are followed for each resident to deliver the right resident centered interventions. The DON stated a fall is a change of condition and Resident 62's smoking CP should have been updated and revised, but it was not. The DON stated when Resident 62's smoking CP was not updated and revised there was a potential that the resident would not be supervised resulting in an incident. The DON stated the facility P&Ps were not followed. During a review of the facility's P&P titled, Care Plan Comprehensive, last reviewed 1/22/2025, the P&P indicated an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, physical, mental and psychosocial needs shall be developed for each resident. Each resident ' s comprehensive care plan is designed to: a. Incorporate identified problem areas. b. Incorporate risk and contributing factors associated with identified problems. c. Build on the resident's individualized needs, strengths, preferences . h. Aid in preventing or reducing declines in the resident's functional status and/or functional levels . Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS). Assessments of resident's are ongoing and care plans arc reviewed and revised as information about the resident and the resident 's condition change. The Interdisciplinary Team is responsible for evaluation and updating of care plans: a. When there has been a significant change in the resident' s condition . c. When the resident has been readmitted to the facility from a hospital stay. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility P&P titled, Smoking, last reviewed 1/22/2025, the P&P indicated the purpose of the policy was to provide a safe environment for residents, staff, and visitors. Licensed Nurse will evaluate resident's who express a desire to smoke upon admission, quarterly, annually, significant change of condition, as needed, and present it to the Interdisciplinary Team (IDT) for review. As identified by the Smoking Evaluation, residents who require assistance and / or monitoring for smoking safety are not allowed to smoke unaccompanied. The IDT will develop an individualized plan for required supervision for residents who smoke. This is documented on the Resident Smoking Evaluation and the Resident's Plan of Care.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on interview and record review, the facility failed to provide care in accordance with professional standards for three (3) of three (3) sampled residents (Resident 51, 137, and 129) investigated for insulin (a hormone that lowers the level of glucose [a type of sugar] in the blood) use by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous ([SQ] -beneath the skin) insulin administration sites. The deficient practice increased the risk that Residents 51,137, and 129 could experience adverse effects (unwanted, unintended result) from same site subcutaneous administration of insulin such as lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Cross Reference F760 Findings: a. During a review of Resident 51's Admission Record, the Admission Record indicated the facility originally admitted Resident 51 on 3/5/2019 and readmitted the resident on 6/11/2024, with diagnoses including type 2 diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and generalized muscle weakness. During a review of Resident 51's Minimum Data Set (MDS - a resident assessment tool) dated 11/9/2024, the MDS indicated Resident 51 had an intact cognition (mental action or process of acquiring knowledge and understanding) and required supervision or touching assistance with eating; partial /moderate assistance with personal hygiene and rolling left and right; substantial/maximal assistance with upper body dressing, lower body dressing, , and sit to lying/lying to sitting; total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 51 received insulin. During a review of Resident 51's History and Physical (H&P) dated 6/19/2024, the H&P indicated Resident 51 did not have the capacity to understand and make decisions. During a review of Resident 51's Order Summary Report, the Order Summary Report indicated the following physician's orders dated: - 6/11/2024: Insulin glargine-yfgn (Lantus -a long-acting insulin) subcutaneous solution pen-injector 100 unit/ml inject 15 units subcutaneously at bedtime for DM. - 6/12/2024 to 10/31/2024; 10/31/2024 to 12/6/2024: Insulin lispro MUV 100 unit/ml vial. Inject subcutaneously before meals and at bedtime for DM. Inject as per sliding scale: if 140 - 199 = 1; < 70 and conscious glucogel (a gel form of glucose which provides a direct source of sugar 1pack or 4 oz juice, if unconscious, give glucagon IM one time and call MD; 200 - 249 = 2; 250 - 299 = 3; 300 - 349 = 4; 350 - 400 = 5. If blood sugar is greater than 400 mg per deciliter (dl - a unit of measurement) administer 5 units and Call MD. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 12/6/2024: INSULIN LISPRO MUV 100UNIT/1ML VIAL Inject subcutaneously before meals and at bedtime for DM inject within 15 mins before meal or with first bite of meal. Inject as per sliding scale: if 140 - 199 = 1; < 70 and conscious glucogel1pack or 4 oz juice, if unconscious, glucagon IM one time and call MD; 200 - 249 = 2; 250 - 299 = 3; 300 - 349 = 4; 350 - 400 = 5. If blood sugar is greater than (> - a unit of measurement) 400 mg per deciliter (dl - a unit of measurement) = give 5 units and call MD. During a concurrent interview and record review on 1/30/2025 at 11:15 a.m., reviewed Resident 51's Order Summary Report, Medication Administration Record (MAR - a daily documentation records used by a licensed nurse to document medications and treatments given to a resident) Location of Administration Report for 12/2024 and 1/2025 with Licensed Vocational Nurse 2 (LVN 2), LVN 2 verified Resident 51 had a physician's order for insulin lispro and insulin glargine and were administered as follows: - Insulin glargine-yfgn subcutaneous solution pen-injector 100 unit/ml 12/05/24 9:30 p.m. subcutaneously Abdomen - LUQ 12/06/24 9:27 p.m. subcutaneously Abdomen - LUQ 12/12/24 9:13 p.m. subcutaneously Abdomen - LUQ 12/13/24 9:23 p.m. subcutaneously Abdomen - LUQ 12/19/24 10:08 p.m. subcutaneously Arm - left 12/20/24 8:59 p.m. subcutaneously Arm - left 12/21/24 9:21 p.m. subcutaneously Abdomen - RLQ 12/22/24 9:50p.m. subcutaneously Abdomen - RLQ 12/26/24 9:24 p.m. subcutaneously Abdomen - LUQ 12/27/24 9:34 p.m. subcutaneously Abdomen - LUQ 1/16/25 9:00 p.m. subcutaneously Abdomen - LUQ 1/17/25 10:00 p.m. subcutaneously Abdomen - LUQ 1/18/25 8:23 p.m. subcutaneously Abdomen - LUQ 1/19/25 8:56 p.m. subcutaneously Abdomen - RLQ 1/20/25 9:37 p.m. subcutaneously Abdomen - RLQ 1/21/25 9:09 p.m. subcutaneously Abdomen - left lower quadrant (LLQ) 1/22/25 9:43 p.m. subcutaneously Abdomen - LLQ (continued on next page)

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Alexandria Care Center	1515 N Alexandria Ave. Los Angeles, CA 90027

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Insulin lispro MUV 100 unit/ml vial: 12/06/24 11:28 a.m. subcutaneously Arm - left 12/07/24 11:26 a.m. subcutaneously Arm - left LVN 2 stated insulin administration sites should be rotated per standards of practice, manufacturer's guidelines. LVN 2 verified Resident 51's MAR indicated the insulin administration sites were not rotated. LVN 2 stated Resident 51's insulin administration sites should have been rotated per manufacturer's guidelines and standards of practice to prevent pain, redness, irritation, and bumps or lumps on the resident's skin. During an interview on 1/30/2025 at 3:00 p.m. with the Director of Nursing (DON), the DON stated the administration sites of insulin should be rotated per as indicated in the manufacturer's guideline and according to standards of practice to prevent complications such as bruising, and lipodystrophy. The DON stated Resident 51's insulin administration site should have been rotated as it placed the resident at risk for pain bruising, lipodystrophy, and amyloidosis. During a review of the facility provided manufacturer's guideline on Lantus (insulin glargine, last revised on 6/2023, the manufacturer's guideline indicate to administer Lantus SQ into the abdominal area, thigh, or deltoid, and rotate injection sites within the same region from one injection to the next to reduce the risk of lipodystrophy and localized cutaneous amyloidosis. Do not inject into the areas of lipodystrophy or localized cutaneous amyloidosis. During a review of the facility provided manufacturer's guideline on, Insulin Lispro Kwikpen, last reviewed on 1/25/2025, the manufacturer's guideline indicated to change or rotate injection sites within the area with each dose to reduce the risk of getting lipodystrophy (pits in ski or thickened skin) and localized cutaneous amyloidosis 9skin with lumps) at the injection sites. - Do not use the exact same spot for each injection. - Do not inject where the skin has pits, is thickened, or has lumps. - Do not inject where the skin is tender, bruised, scaly or hard, or into scars or damaged skin. During a review of the facility's policy and procedure (P&P) tilted, Insulin Administration, last reviewed 1/25/2025, the P&P indicated a purpose to provide guidelines for the safe administration of insulin to residents with diabetes. Select an injection site. The P&P further indicated: a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 137's Admission Record, the Admission Record indicated the facility originally admitted Resident 137 on 5/21/2024 and readmitted the resident on 1/9/2025, with diagnoses including congestive heart failure (CHF - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), type 2 diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing), and generalized muscle weakness. During a review of Resident 137's MDS dated [DATE], the MDS indicated Resident 137 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 137 received insulin. During a review of Resident 137's History and Physical (H&P) dated 1/12/2025, the H&P indicated Resident 137 did not have the capacity to understand and make decisions. During a review of Resident 137's Order Summary Report, the Order Summary Report indicated the following physician's orders dated: - 12/1/2024 to 12/10/2025; 12/10/2024 to 1/9/2025: Insulin lispro (a short acting insulin) injection solution inject subcutaneously before meals and at bedtime for DM 2 to inject 15 minutes before meals or with first bite of the meal. Inject as per sliding scale (increasing administration of the pre?meal insulin dose based on the blood sugar level before the meal): if 71 - 150 = 0 ; less than (< - a unit of measurement) 70 if patient is conscious, give four (4) ounces (oz - a unit of measurement) of juice. If unconscious, give glucagon (a natural hormone the body makes which prevents the blood sugar from dropping too low) 1 milligram (mg - a unit of measurement) intramuscularly (IM - into the muscle tissue) one time. Notify physician (MD); 151 - 200 = 1 unit; 201 - 250 = 2; 251 - 300 = 3; 301 - 350 = 4; 351 -400 = 6; above 401 = 8. - 1/9/2025: Insulin lispro injection solution inject subcutaneously before meals and at bedtime for DM 2. Inject as per sliding scale: if 151 - 200 = 1; if blood sugar is < 70 and conscious give 4 oz of juice. If unconscious give glucagon 1mg IM one time and notify MD; 201 - 250 = 2; 251 - 300 = 3; 301 - 350 = 4; 351 - 400 = 6 if blood sugar above 400, give 8 units and notify MD for DM 2. - 9/6/2024 to 12/1/2024: Insulin glargine (Lantus - a long-acting insulin) subcutaneous solution 100 unit per ml (unit/ml - a unit of measurement) inject 50 units subcutaneously two times a day for DM 2. - 1/9/2025: Lantus solostar subcutaneous solution pen-injector 100 unit/ml. inject 40 units subcutaneously two times a day for DM 2. During a concurrent interview and record review on 1/30/2025 at 11:00 a.m., reviewed Resident 137's Order Summary Report, Medication Administration Record (MAR - a daily documentation records used by a licensed nurse to document medications and treatments given to a resident) Location of Administration Report for 12/2024 and 1/2025 with Licensed Vocational Nurse 2 (LVN 2), LVN 2 verified Resident 137 had a physician's order for insulin lispro and Lantus and were administered as follows: - Insulin lispro injection solution: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/02/24 9:02 p.m. subcutaneously Arm - right 12/03/24 6:06 a.m. subcutaneously Arm - right 12/04/24 5:07 p.m. subcutaneously Abdomen - left upper quadrant (LUQ) 12/04/24 9:14 p.m. subcutaneously Abdomen - LUQ 12/11/24 12:22 p.m. subcutaneously Arm - left 12/11/24 6:06 p.m. subcutaneously Arm - left 12/11/24 9:11 p.m. subcutaneously Arm - right 12/12/24 6:11 a.m. subcutaneously Arm - right 12/14/24 8:24 p.m. subcutaneously Abdomen - LUQ 12/15/24 5:26 p.m. subcutaneously Abdomen - LUQ 12/18/24 11:46 a.m. subcutaneously Abdomen - right lower quadrant (RLQ) 12/18/24 4:30 p.m. subcutaneously Abdomen - RLQ 1/22/25 4:36 p.m. subcutaneously Arm - right 1/22/25 9:22 p.m. subcutaneously Arm - right 1/23/25 5:59 a.m. subcutaneously Arm - left 1/23/25 11:50 a.m. subcutaneously Arm - left 1/24/25 6:16 a.m. subcutaneously Arm - left - Lantus solostar subcutaneous solution pen-injector 100 unit/ml 1/19/25 10:47 a.m. subcutaneously Abdomen - RLQ 1/19/25 9:12 p.m. subcutaneously Abdomen - RLQ 12/18/24 9:00 p.m. subcutaneously Abdomen - LUQ 12/19/24 9:33 p.m. subcutaneously Abdomen - LUQ (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN 2 stated insulin administration sites should be rotated per standards of practice, manufacturer's guidelines. LVN 2 verified Resident 137's MAR indicated the insulin administration sites were not rotated. LVN 2 stated Resident 137's insulin administration sites should have been rotated per manufacturer's guidelines and standards of practice to prevent pain, redness, irritation, and bumps or lumps on the resident's skin. During an interview on 1/30/2025 at 3:00 p.m. with the Director of Nursing (DON), the DON stated the administration sites of insulin should be rotated per as indicated in the manufacturer's guideline and according to standards of practice to prevent complications such as bruising, and lipodystrophy. The DON stated Resident 137's insulin administration site should have been rotated as it placed the resident at risk for pain bruising, lipodystrophy, and amyloidosis. During a review of the facility provided manufacturer's guideline on Lantus (insulin glargine, last revised on 6/2023, the manufacturer's guideline indicate to administer Lantus SQ into the abdominal area, thigh, or deltoid, and rotate injection sites within the same region from one injection to the next to reduce the risk of lipodystrophy and localized cutaneous amyloidosis. Do not inject into the areas of lipodystrophy or localized cutaneous amyloidosis. During a review of the facility provided manufacturer's guideline on, Insulin Lispro Kwikpen, last reviewed on 1/25/2025, the manufacturer's guideline indicated to change or rotate injection sites within the area with each dose to reduce the risk of getting lipodystrophy (pits in ski or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. - Do not use the exact same spot for each injection. - Do not inject where the skin has pits, is thickened, or has lumps. - Do not inject where the skin is tender, bruised, scaly or hard, or into scars or damaged skin. During a review of the facility's policy and procedure (P&P) tilted, Insulin Administration, last reviewed 1/25/2025, the P&P indicated a purpose to provide guidelines for the safe administration of insulin to residents with diabetes. Select an injection site. The P&P further indicated: a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). 43455 c. During a review of Resident 129's Admission Record dated 1/30/2025, the Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including DM2. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 129's Order Summary Report, dated 1/30/2025, the Order Summary Report indicated Resident 129 was prescribed Regular (short-acting insulin) insulin to inject per sliding scale (insulin dosing plan whereby the amount of insulin administered depends on the resident's blood sugar level,) SQ before meals and at bedtime related to DM2, starting 4/15/2024. During a review of Resident 129's MAR for January 2025, the MAR indicated Resident 129 was prescribed Regular insulin to inject per sliding scale SQ before meals and at bedtime related to DM2, at 6:30 a.m., 11:30 a.m., 4:30 p.m. and 9 p.m. During the same review, the MAR indicated Regular Insulin was administered SQ by the following licensed nurses, on the following days, times, and sites: 1/12/25 two (2) un at 11:30 a.m. on left arm by LVN 6 1/12/25 two (2) un at 4:30 p.m. on left arm by LVN 7 1/12/25 two (2) un at 9 p.m. on left arm by LVN 7 1/16/25 two (2) un at 11:30 a.m. on left arm by LVN 6 1/16/25 two (2) un at 9 p.m. on left arm by LVN 8 During a concurrent interview and record review on 1/30/2025 at 2:18 p.m., with the Director of Nursing (DON,) the DON reviewed Resident 129's MAR for January 2025. The DON stated that Resident 129's MAR indicated there were instances where the insulin administration sites were not rotated by several licensed nurses, as expected by facility policy, standard of practice and manufacturer guidelines. The DON stated the failure of the licensed nurses to rotate insulin administration sites could cause harm to Resident 129 by causing lipodystrophy (skin abnormalities such as lumps in the skin or thickened skin) at the repeated administration sites. The DON stated not rotating insulin administration sites was considered a significant medication error. During a review of the facility's Policy & Procedures (P&P,) Insulin Administration, last reviewed 1/22/2025, the P&P indicated: To provide guidelines for the safe administration of insulin to residents with diabetes. 16.b. injection sites should be rotated. During a review of facility provided manufacturer's guide Highlights of Prescribing Information for Humulin R (brand name for Regular insulin) dated June 2023, the guide indicated to Rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis (skin with lumps).

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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. 38552 Based on observation, interview, and record review, the facility failed to provide quality of care in accordance with professional standards of practice to meet the resident's physical, mental, psychosocial needs for one of one sampled resident (Resident 147) investigated under rehab and restorative care area by failing to: 1. Conduct the interdisciplinary team meeting (IDT-a coordinated group of experts from several different fields) with the resident's responsible party regarding the resident's refusals to participate in physical therapy treatments. 2. Inform Resident 147's physician regarding the resident's refusals to participate in physical therapy treatments. These deficient practices had the potential to result in Resident 147's decline in mobility, strength, and overall physical function, leading to increased dependence to providers. Findings: During a review of Resident 147's Admission Record, the Admission Record indicated the facility admitted the resident on 11/29/2024 with diagnoses including nondisplaced intertrochanteric fracture (break-in bone) of right femur (thigh bone), orthopedic aftercare (follow-up care and treatment after surgery or an injury to bones or joints), and rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility). During a review of Resident 147's History and Physical (H&P), dated 12/1/2024, the H&P indicated the plan for rehabilitation as the resident has good rehab potential. During a review of Resident 147's Order Summary Report, the Order Summary Report indicated the following: - Physical Therapy (PT) - Evaluation and Treatment as recommended, dated 11/29/2024. - PT clarification of treatment for therapeutic exercises, neuromuscular reeducation, therapeutic activities, and gait training daily for five (5) days per week for 30 days, dated 11/30/2024. - Continue PT treatment for therapeutic exercises, neuromuscular reeducation, therapeutic activities, gait training daily for 5 days per week for 30 days, dated 12/30/2024. During a review of Resident 147's Minimum Data Set (MDS - a resident assessment tool), dated 12/3/2024, the MDS indicated the resident had the ability to make self understood and understand others. The MDS indicated the resident had an impairment on one side on the lower extremity that interfered with daily functions or placed the resident at risk of injury. The MDS indicated the resident required maximal assistance with the ability to roll left and right, sit to lying, lying to sitting on one side of bed, sit to stand, chair/bed-to-chair transfer. (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 observation on 1/30/2025 at 3:10 p.m., at Resident 147's bedside with Physical Therapist 1 (PT 1), PT 1 asked the resident if they could change the sheet; the resident could roll to her right but refused to move. PT 1 asked the resident to change position from lying to sitting on the side of the bed. PT 1 assisted resident to sitting side of bed position. Resident 147 stated she wants to lie back to bed. Resident 147 refused to continue physical therapy treatment. During a concurrent interview and record review on 1/31/2025 at 2:32 p.m., with PT 1, reviewed Resident 147's Missed Visit Details, the following were reviewed: - 12/12/2024 -refused treatment even with maximum encouragement. - 12/13/2024 - refused treatment family at present and unable to encourage resident to participate in therapy. - 12/16/2024 - refused treatment. - 12/17/2024 - refused treatment. - 1/10/2025, refused treatment multiple attempts and max encouragement. PT 1 stated resident's missed visit details was reported to the Director of Rehabilitation (DOR) who was informed that they were having issues with the resident. PT 1 stated the DOR will then involve social services and the interdisciplinary team members. During a concurrent interview and record review on 1/31/2025 at 1:55 p.m., with Social Services Assistant 1 (SSA 1), Resident 147's Social Services Assessment and Documentation dated 12/3/2024 was reviewed. SSA 1 stated they discussed with the rehab team the resident's progress in the minutes, but it was not documented in the resident's progress notes. SSA 1 stated 12/3/2024 was the last contact she had with the resident's RP. During an interview on 1/31/2025 at 2:07 p.m. with Responsible Party 1 (RP 1), RP 1 stated initially Resident 147 participated in therapy. RP 1 stated he could not come every day to encourage Resident 147 with therapy. RP 1 stated he saw Resident 147 refusals to participate with therapy. RP 1 stated the goal for Resident 147 is to go home and doing the exercise will help her get strong enough to go home with him (RP 1). RP 1 stated PT 1 has spoken to him about Resident 147's refusing to participate and he (RP 1) was present in some of those situations. RP 1 stated Resident 147 does not even want to open her eyes, her mind is okay, but she (Resident 147) just chose not to do the rehab exercises. During an interview on 1/31/2025 at 2:42 p.m. with PT 1, PT 1 stated Resident 147 required maximum encouragement including talking to the resident and explaining what they are going to do; approach more than once or keep trying; explain to the resident while providing the care/treatment; continually encourage resident to participate; try different approaches such as with rolling left and right and bed they can ask the resident would they like their sheet changed. PT 1 stated the potential outcome for the resident for multiple missed visit details would be stiffness, atrophy of the legs, loss of muscle strength, loss of sitting balance and tolerance, and at risk for skin breakdown if the resident is in bed all the time. PT 1 stated the care plan should be revised to reflect the updated goal. (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 1/31/2025 at 4:08 p.m., with MDS Nurse 1 (MDSN 1), MDSN 1 stated she was part of the IDT meeting on 12/10/2024, 12/17/2024 and had discussed Resident 147's refusal to participate in physical therapy treatments. MDSN 1 stated they should have developed the care plan when the resident had multiple refusals. MDSN 1 stated this was not done and should have been documented in the IDT notes to reflect that it was discussed and addressed. MDSN 1 stated purpose of IDT is to ensure as a team they are providing and ensuring interventions and goals are achieved and go home. MDSN 1 stated any changes family and MD will be notified. MDSN 1 stated the resident's MD was not notified. MDSN 1 stated the resident potential for decline such as contractures, skin injury, if the resident is not being moved and address any approaches needed for skilled rehab. During an interview on 1/31/2025 at 4:55 p.m., with the DON, the DON stated she was made aware of Resident 147's episodes of refusals and participating with rehab. The DON stated the IDT should have identified this and should have discussed with the son and should have been documented. The DON stated moving forward they would need to update and document and prove that they tried their due diligence that resident refused. The DON stated the potential for the resident's continuous refusal would be a decline in their functional level. During a review of the facility's policy and procedure (P&P) titled, Requesting, Refusing and/or Discontinuing Care or Treatment, last reviewed and approved on 1/22/2025, the P&P indicated 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: a. determine why he or she is requesting, refusing, or discontinuing care or treatment; b. try to address his or her concerns and discuss alternative options; and c. discuss the potential outcomes or consequences (positive or negative) of the decision . 7. Information relating to the request, refusal, or discontinuation of treatment are documented in the resident's medical record . 9. The healthcare practitioner must be notified of refusal or treatment, in a time frame determined by the resident's condition and potential serious consequences of the request. During a review of the facility's P&P titled, Care Plan Comprehensive, last reviewed and approved on 1/22/2025, the P&P indicated an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, physical, mental and psychosocial needs shall be developed for each resident. The facility's IDT, in coordination with the resident and/or his/her family or representative, must develop and implement a comprehensive person-centered care for each resident. Each resident ' s comprehensive care plan is designed to: a. Incorporate identified problem areas. b. Incorporate risk and contributing factors associated with identified problems. c. Build on the resident's individualized needs, strengths, preferences . f. Reflect treatment goals, timetables, and objectives in measurable outcomes . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS). Assessments of resident's are ongoing and care plans arc reviewed and revised as information about the resident and the resident 's condition change.

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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. 38552 Based on observation, interview, and record review, the facility failed to ensure residents received care consistent with professional standards of practice to prevent pressure injury (also called pressure ulcer, the breakdown of skin integrity due to pressure) for one of one sampled resident (Resident 86) investigated under pressure injury by failing to ensure Resident 86's low air loss mattress (LALM, a mattress that helps prevent and treat pressure injuries by circulating air and relieving pressure on the body) had a physician's order and care plan developed. This deficient practice had the potential for the development and worsening of pressure injuries to Resident 86. Findings: During a review of Resident 86's Admission Record, the Admission Record indicated the facility admitted the resident on 8/27/2021 with diagnoses including chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and dementia (a progressive state of decline in mental abilities). During a review of Resident 86's History and Physical (H&P), dated 8/31/2023, the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 86's Braden Scale for Predicting Pressure Risk, dated 9/19/2024, the Braden Scale for Predicting Pressure Risk indicated the resident has mild risk for pressure ulcers. During a review of Resident 86's Minimum Data Set (MDS-a resident assessment tool), dated 11/12/2024, the MDS indicated the resident had the ability to understand others and had the ability to make self understood. The MDS indicated the resident required moderate assistance with rolling left and right on the bed and required maximal assistance with lying to sitting on side of bed and with no back support. The MDS indicated the resident has pressure reducing device for bed. During an observation on 1/28/2025 at 9:21 a.m., at Resident 86's bedside, resident was lying in bed with LALM settings at 400 pounds (lbs - a unit of measurement). During a concurrent observation and interview on 1/31/2025 at 11:45 a.m., with Certified Nursing Assistant 4 (CNA 4) at Resident 86's bedside, resident was lying in bed with LALM settings at 350 lbs with red light on low pressure. CNA 4 stated the resident's LALM will alarm every 15 minutes (min-a unit of measurement) so he sets the LALM settings beyond the resident's weight. CNA 4 stated he can adjust the weight settings up or down, usually sets it at maximum, but set it at 350 lbs today. CNA 4 stated if he sets it at 150 lbs of the resident's weight the LALM will alarm. CNA 4 stated this has been going on for about 3 months now and has informed the previous charge nurse but has not informed Licensed Vocational Nurse 5 (LVN 5) that day. CNA 4 stated ereCNAs can adjust the LALM settings. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/31/2025 at 11:53 a.m., with LVN 5, LVN 5 stated he was not aware of Resident 86's LALM not working. LVN 5 stated only the treatment nurse can adjust on the resident's mattress settings. During a concurrent interview and record review on 1/31/2025 at 12:00 p.m. with Registered Nurse 2 (RN 2), Resident 86's physician orders were reviewed. RN 2 stated there was no order for the use of the LALM. RN 2 stated there should be an order for the use of the LALM as part of the monitoring and treatment for the resident. During a concurrent interview and record review on 1/31/2025 at 12:03 p.m. with RN 2, Resident 86's care plans were reviewed. RN 2 stated there was no care plan developed for the use of the LALM. During an interview on 1/31/2025 at 4:41 p.m., with the Director of Nursing (DON), the DON stated LALM are intended for residents who have multiple pressure ulcers or are at high risk for development of pressure ulcer; all residents have a pressure reducing mattress which is pressure relieving and can help prevent the resident from developing pressure ulcers. The DON stated the use of LALM needs to have settings in place and the treatment nurse would place a sticker on the machine of what would the setting be. The DON stated there would be a physician's order for the use of LALM. The DON stated CNAs cannot manipulate the LALM settings and they should report the issue to their charge nurse or treatment nurse. The DON stated the LALM is for prevention of pressure ulcers and a care plan should be developed. The DON stated the resident could potentially be at risk for pressure ulcer when care plan interventions are not implemented correctly. During a review of the facility's policy and procedure (P&P) titled, Positioning/Transfer and Changing Resident with Airloss Mattress, last reviewed and approved on 1/22/2025, the P&P indicated the facility establishes techniques, responsibilities, and protocols for transferring, repositioning and changing of residents on an airloss mattress to ensure safety of the resident and employee. The P&P indicated low air loss mattresses are designed to distribute the patient's body weight over a broad surface area and help prevent skin breakdown. During a review of the facility's P&P titled, Physician Orders, last reviewed and approved on 1/22/2025, the P&P indicated this policy will ensure that all physician orders are complete and accurate. The P&P indicated other orders will include a description complete enough to ensure clarity of the physician's plan of care. The P&P indicated the licensed nurse receiving the order will be responsible for documenting and implementing the order. Medication/treatment orders will be transcribed onto the appropriate resident administration record. During a review of the facility P&P titled, Care Plan Comprehensive, last reviewed and approved on 1/22/2035, the P&P indicated an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, physical, mental and psychosocial needs shall be developed for each resident. The facility's IDT, in coordination with the resident and/or his/her family or representative, must develop and implement a comprehensive person-centered care for each resident. Each resident ' s comprehensive care plan is designed to: a. Incorporate identified problem areas. b. Incorporate risk and contributing factors associated with identified problems. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Build on the resident's individualized needs, strengths, preferences . f. Reflect treatment goals, timetables, and objectives in measurable outcomes . The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS). Assessments of resident's are ongoing and care plans arc reviewed and revised as information about the resident and the resident 's condition change. During a review of the facility's operator's manual, titled Med Aire Plus 8 Alternating Pressure and Low Air Loss Mattress Replacement System with Defined Perimeter, undated, the manual indicated mute button - the audible/visible alarms turns on either when the pressure is low, or the system fails to alternate . The weight setting buttons (+) and (-) can be used to adjust the pressure of the inflated cells based on the patient's weight. As the weight increases, the pressure level indicator lights up (green) with each added level of pressure . Low pressure indicator light (red) flickers when the pressure is below the pre-defined level.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on observation, interview, and record review, the facility failed to ensure the resident environment was free of accident hazards for four (4) of five (5) sampled residents (Residents 94, 21, 27 and 129's) investigated under accidents by failing to: 1. Ensure there was no furniture or equipment on top of Resident 94, 21, and 27's floor mats for a long period of time. 2. Ensure Resident 129's bed was not left in the elevated/high position while unattended by staff. These deficient practices had the potential to place Residents 94, 21, 27, and 129 at risk for increased chances of incurring injury such as falls with fracture (a break or crack in a bone) and even death. Findings: a. During a review of Resident 94's Admission Record, the Admission Record indicated the facility originally admitted Resident 94 into the facility on [DATE] and readmitted on [DATE], with diagnoses including type two (2) diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN - high blood pressure), and generalized muscle weakness. During a review of Resident 94's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 12/10/2024, the MDS indicated Resident 94 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required setup or clean-up assistance with eating; supervision or touching assistance with oral hygiene; partial/moderate assistance to substantial/maximal to total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 94's care plan for risk of falls initiated on 12/17/2024, the care plan included interventions to maintain a clutter free environment in the resident's room and consistent furniture arrangement to prevent falls. During a review of Resident 94's History and Physical (H&P) dated 12/20/2024, the H&P indicated Resident 94 had the capacity to understand and make decisions. During a review of Resident 94's Order Summary Report, the Order Summary Report included a physician's order dated 1/20/2025 to apply a non-skid mat on both sides of bed for safety. During a review of Resident 94's fall risk evaluation form dated 12/17/2024 and 1/26/2025, the fall risk evaluations indicated Resident 94 was at risk for falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 1/28/2025 at 9:52 a.m., while inside Resident 94's room with Licensed Vocational Nurse 3 (LVN 3), LVN 3 verified Resident 94's overbed table was placed on top of the right floor mat. LVN 3 stated he was not aware that the overbed table could not be placed on top of the floor mat for a long period of time. LVN 3 verified Resident 94's overbed table wheels left an indentation on the floor affecting the integrity of the floor mat which can affect resident safety in the event a fall. LVN 3 stated Resident 94's overbed table can be unstable and fall on the resident or Resident 94 can hit the table when he tries to get out of bed unassisted. During an interview on 1/30/2025 at 2:30 p.m. with the Director of Nursing (DON), the DON stated the resident environment should be clutter free and there should be no equipment or furniture on top of the floor mats, as it can affect the integrity of the mat and get torn. The DON verified the manufacturer's guideline for Floor Mat 1 (FM 1) indicated to avoid placing furniture or equipment on the mat as it can cause indentations. The DON stated Resident 94's environment should have been clutter free to include not leaving the overbed table on top of the floor mat. The DON stated the overbed table can be unstable and might fall on the resident. The DON stated Resident 94 could also hit the table when he tries to get out of bed unassisted which can lead to injury. b. During a review of Resident 27's Admission Record, the Admission Record indicated the facility originally admitted the resident into the facility on [DATE] and readmitted on [DATE] with diagnoses including type two (2) diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN - high blood pressure), and generalized muscle weakness. During a review of Resident 27's care plan for risk for falls initiated on 3/12/2024 and last revised on 9/16/2024, the care plan indicated floor mats on both sides of the bed and assist resident or caregiver to organize belongings for a clutter-free environment in the resident's room and consistent furniture arrangement as a few of the interventions to prevent falls. During a review of Resident 27's fall risk evaluation forms dated 9/23/2024 and 9/26/2024, the fall risk evaluations indicated Resident 27 was a risk for falls. During a review of Resident 27's History and Physical (H&P) dated 9/26/2024, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 27's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 11/6/2024, the MDS indicated the resident had an intact cognition (mental action or process of acquiring knowledge and understanding) and required setup or clean-up assistance with eating; supervision or touching assistance with oral hygiene and personal hygiene; partial/moderate assistance with upper body dressing and rolling left and right; total assistance with toileting and bathing; substantial/maximal from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 1/28/2025 at 10:20 a.m., while inside Resident 27's room with Certified Nursing Assistant 1 (CNA 1), CNA 1 confirmed Resident 27's overbed table was placed on top of the left floor mat. CNA 1 stated it had always been Resident 27's preference to have the overbed table on top of the floor mat. CNA 1 stated she was not aware that the overbed table could not be placed on top of the floor mat for a long period of time. CNA 1 verified Resident 27s overbed table wheels were unstable when moved. CNA 1 stated Resident 27's overbed table can fall on the resident if unstable or Resident 27 can hit the table when she rolls out of bed by accident and get injured. During a concurrent observation and interview on 1/28/2025 at 10:25 a.m., while inside Resident 27's room with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated she did not know there should be no equipment or furniture placed on top of the floor mat. LVN 2 verified that the table was unstable when moved and can fall on the resident which may lead to injury. During an interview on 1/30/2025 at 2:30 p.m. with the Director of Nursing (DON), the DON stated the resident environment should be clutter free and there should be no equipment or furniture on top of the floor mats as it can affect the integrity of the mat and get torn. The DON verified the manufacturer's guideline for Floor Mat 1 (FM 1) indicated to avoid placing furniture or equipment on the mat as it can cause indentations. The DON stated Resident 94's environment should have been clutter free to include not leaving the overbed table on top of the floor mat. The DON stated the overbed table can be unstable and might fall on the resident. The DON stated Resident 27 could also hit the table when she tries to get out of bed unassisted which can lead to injury. c. During a review of Resident 21's Admission Record, the Admission Record indicated the facility admitted the resident into the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), hypertension (HTN - high blood pressure), and generalized muscle weakness. During a review of Resident 21's History and Physical (H&P) dated 12/5/2024, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 21's fall risk evaluation forms dated 12/6/2024, the fall risk evaluations indicated Resident 27 was a risk for falls. During a review of Resident 21's care plan for risk of falls initiated on 12/6/2024 and last revised on 1/7/2025, the care plan included interventions to place the floor mat on the right side and maintain a clutter-free environment in the resident's room and consistent furniture arrangement to prevent falls. During a review of Resident 21's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 12/13/2024, the MDS indicated the resident had intact cognition (mental action or process of acquiring knowledge and understanding) and required substantial/maximal assistance to total assistance with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 1/28/2025 at 9:39 a.m., while inside Resident 21's room with Registered Nurse 2 (RN 2), RN 2 verified Resident 21's overbed table was placed on top of the right floor mat. RN 2 stated she was not sure that the table could not be placed on top of the floor mat. RN 2 verified the overbed table was unstable when moved. RN 2 stated the placement of the table placed Resident 21 at risk for getting injured when the table falls on the resident or Resident 21 can hit the table when she rolled out of bed by accident. During an interview on 1/30/2025 at 2:30 p.m. with the Director of Nursing (DON), the DON stated the resident environment should be clutter free and there should be no equipment or furniture on top of the floor mats as it can affect the integrity of mat and get torn. The DON verified the manufacturer's guideline for Floor Mat 1 (FM 1) indicated to avoid placing furniture or equipment on the mat as it can cause indentations. The DON stated Resident 94's environment should have been clutter free to include not leaving the overbed table on top of the floor mat. The DON stated the overbed table can be unstable and might fall on the resident. The DON stated Resident 27 could also hit the table when she tries to get out of bed unassisted which can lead to injury. During a review of the facility provided undated manufacturer's guideline on Floor Mat 1 (FM 1), undated, the manufacturer's guideline indicated to avoid placing furniture or equipment on the mat as this may cause permanent indentations to occur. During a review of the facility's policy and procedure (P&P) titled, Quality of Life - Accommodation of Needs, last reviewed 1/25/2025, the P&P indicated: - The facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity and well-being - The resident individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, shall be evaluated upon admission and reviewed on an ongoing basis. - Adaptations may be made to the physical environment including the resident's bedroom and bathroom which include arranging furniture as the resident requests, providing the arrangement is safe, his or her roommate agrees, and space allows. 44244 d. During a review of Resident 129's Admission Record (AR), the AR indicated the facility admitted the resident into the facility on [DATE] and readmitted the resident on 4/15/2024 with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and adult failure to thrive (a state of decline due to underlying physical, mental, or psychosocial conditions). During a review of Resident 129's Order Summary Report, the report indicated orders for fall precautions (interventions to reduce the risk of injury from falls), dated 4/16/2024. During a review of Resident 129's History and Physical (H&P), dated 4/24/2024, the H&P indicated the resident did not have the capacity to make decisions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 129's Order Summary Report, the report indicated orders for fall precautions - fall mats (a cushioned floor pad designed to help prevent injury should a person fall) on both sides of the bed, dated 5/2/2024. During a review of Resident 129's Minimum Data Set (MDS - resident assessment tool), dated 1/1/2025, the MDS indicated the resident sometimes had the ability to make herself-understood and sometimes was able to understand others. The MDS further indicated the resident was dependent on staff for bathing and dressing; required substantial/maximal assistance from staff for oral and personal hygiene, toileting, and mobility in bed and for transfers. During a review of Resident 129's Care Plan (CP) titled, Resident is at risk for falls: impaired mobility ., initiated on 2/8/2024 and last revised on 1/7/2025, the care plan indicated a goal that the resident would have no falls and to assist the resident with consistent furniture arrangement and place floor mats on both sides of the bed. During an observation on 1/28/2025 at 10 a.m., Resident 129 was lying in bed. Resident 129 was awake and did not verbally respond. Resident 129's bed was elevated to the high position. There were no staff present in the room and fall mats were present on both sides of the resident's bed. During a concurrent observation and interview on 1/28/2025 at 10:10 a.m., with Certified Nursing Assistant 3 (CNA 3), CNA 3 entered Resident 129's room and stated the resident's bed was high. CNA 3 stated she assisted Resident 129 with breakfast and then went to another resident's room and did not lower the bed. CNA 3 stated resident 129 had fall mats but she was not sure if the resident was a risk for falls. CNA 3 stated she would find out if the resident was a fall risk. CNA 3 exited Resident 129's room and left the resident's bed in the high elevated position. During a follow up observation and interview on 1/28/2025 at 10:15 a.m., with CNA 3, CNA 3 returned to Resident 129's room and stated the resident was a fall risk and she should not have left the resident's bed in the high position because the resident was considered at risk for falls. CNA 3 was observed lowering Resident 129's bed to the lowest position. During an interview on 1/31/2025 at 8:30 a.m., with the Director of Staff Development (DSD), the DSD stated resident beds should not be left in the high position when unattended by staff because a resident could get nervous and fall. The DSD stated there was a higher risk for injuries, like fractures, when a resident falls from the bed in the high position. During a concurrent interview and record review on 1/31/2025, at 9:30 a.m., with the Director of Nursing (DON), the DON reviewed the facility policy regarding fall management. The DON stated Resident 129 has confusion and the resident's bed should be in the lowest position when unattended by staff, but it wasn't when CNA 3 left the resident's bed up and left the resident's room. The DON stated the bed in the low position would minimize the risk for injury from falls. The DON stated the facility's policy and procedures were not followed when Resident 129's bed was left up. (continued on next page)

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F 0689 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, Fall Risk Assessment last reviewed on 1/22/2025, the P&P indicated the nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident centered fall prevention plan based on relevant assessment information. The staff will seek to identify environmental factors that may contribute to falling. During a review of the facility's P&P titled, Fall Management, last reviewed on 1/22/2025, the P&P indicated the purpose of the policy was to reduce the risk for falls and minimize the actual occurrence of falls. Patients will be assessed for fall risk as part of the nursing assessment process. Those determined to be at risk for falls will receive appropriate interventions to reduce the risk and minimize injury.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 43988 Based on observation, interview, and record review, the facility failed to ensure residents with a urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) received appropriate care and services to prevent urinary tract infections (UTI, an infection in the bladder/urinary tract) for one (1) out of one sampled resident (Resident 137) investigated under the urinary catheter or UTI care area when the facility failed to ensure Residents 137's urinary catheter tubing did not have a loop while hanging on the side the bed. This deficient practice had the potential to result in the resident's urine to not flow freely which may lead to the development of an UTI. Findings: a. During a review of Resident 137's Admission Record, the admission record indicated the facility originally admitted Resident 137 on 5/21/2024 and readmitted the resident on 1/9/2025, with diagnoses including congestive heart failure (CHF - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), type 2 diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing), and generalized muscle weakness. During a review of Resident 137's Minimum Data Set (MDS - a resident assessment tool) dated 1/11/2025, the MDS indicated Resident 137 had impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 137 had an indwelling catheter. During a review of Resident 137's History and Physical (H&P) dated 1/12/2025, the H&P indicated Resident 137 did not have the capacity to understand and make decisions. During a review of Resident 137's Order Summary Report, the Order Summary Report indicated the following physician's orders dated 1/13/2025: - Change indwelling catheter when occluded or leaking as needed. - Perform indwelling catheter care every day shift and as needed. - Indwelling catheter 16 French (FR - a unit of measurement) with ten (10) milliliters (ml - a unit of measurement) balloon to bedside straight drainage for urinary retention. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 1/28/2025 at 10:38 a.m. while inside Resident 137's room with Licensed Vocational Nurse 2 (LVN 2), LVN 2 verified Resident 137's urinary catheter tubing had a loop, and the loop had urine inside. LVN 2 stated the urinary catheter tubing should not have a loop as the urine will not flow freely or back up into the bladder and cause a UTI. LVN 2 stated Resident 137's should have no loop as it placed the resident at risk for acquiring UTI when the urine in the tubing cannot flow freely and possibly back up into the bladder. During an interview on 1/30/2025 at 2:30 p.m. with the Director of Nursing (DON), the DON stated urinary catheter tubing should be positioned properly on the side of the bed to prevent loops or kink as the urine will not flow freely and back up into the bladder and nurses should check every time they go to the resident's room. The DON stated Resident 137's urinary catheter tubing should have been placed properly on the side of the bed to prevent kinks or loops as the urine will not flow freely and back up into the bladder which may lead to an UTI. During a review of the facility's policy and procedure (P&P) titled, Urinary Tract Infections (Catheter-Associated), Guidelines for Preventing, last reviewed on 1/25/2025, the P&P indicated to maintain unobstructed urine flow by keeping the catheter and tubing free of kinks.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38552 Based on observation, interview, and record review, the facility failed to monitor Resident 69's change in condition for significant weight loss for one of two sampled residents (Resident 69) investigated under the nutrition care area. This deficient practice had the potential to place the resident at risk for further weight loss. Findings: During a review of Resident 69's Admission Record, the Admission Record indicated the facility admitted the resident on 11/18/2019 with diagnoses including type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN-high blood pressure), and dementia (a progressive state of decline in mental abilities). During a review of Resident 69's Weights and Vitals Summary, the Weights and Vitals Summary indicated: - 1/2/2025, 152.8 pounds (lbs. -a unit of measurement) - 12/2/2024, 163.7 lbs. - 11/4/2024, 165.7 lbs. - 10/6/2024, 165.5 lbs. - 7/3/2024, 170.3 lbs. During a review of Resident 69's Nutritional Assessment, dated 1/2/2025, the Nutritional Assessment indicated the resident had significant weight change with recommendations to monitor weight trend, meal intake, and labs as available. The Nutritional Assessment indicated the goals of minimizing further weight loss and maintaining meal intake greater than 75 percent (%) through next review date. During a review of Resident 69's Change in Condition (COC- a major decline in a resident's status) Evaluation, dated 1/5/2025, the COC Evaluation indicated the resident had a weight loss of 11 lbs. in 30 days and a weight loss of 17 lbs. in 180 days. During a review of Resident 69's weight loss care plan, dated 1/6/2025, the care plan indicated the goal of having no complications from weight variance and with interventions including monitoring for changes in nutritional status (changes in intake, ability to feed self, unplanned weight loss/gain, abnormal labs) and reporting to food and nutrition/physician as indicated. During a concurrent observation and interview on 1/29/2025 at 1:23 p.m. with Registered Nurse 2 (RN 2), RN 2 stated Resident 69 ate 50% of his meal. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/29/2025 at 1:36 p.m., with RN 2, RN 2 stated Resident 69 had a COC for significant weight loss on 1/5/2025 and that there should have been a monitoring as to why the resident was losing weight. RN 2 stated it is important because resident could lead to health deterioration and malnutrition (a condition that occurs when your diet lacks the nutrients your body needs to function). During a concurrent interview and record review on 1/29/2025 at 3:19 p.m., with Licensed Vocational Nurse 4 (LVN 4), Resident 69's Progress Notes 1/1/2025 to 2/1/2025 was reviewed. LVN 4 stated she completed the COC on 1/5/2025, but she did not finish it. LVN 4 stated she remembers calling the doctor and family, but she does not recall what time. LVN 4 stated there should have been documentation of monitoring after the COC was identified. LVN 4 stated the resident would be at risk for further weight loss if (Resident 69) he was not monitored. During an interview on 1/31/2025 at 4:52 p.m., with the Director of Nursing (DON), the DON stated there should have been a 72- hour monitoring for any changes in condition. The DON stated when the monitoring is not done there is a potential for not implementing the interventions that are needed to prevent Resident 69 from further weight loss. During a review of the facility's policy and procedure (P&P) titled, Weight Management, last reviewed and approved on 1/22/2025, the P&P indicated this policy to determine possible causes of significant weight change . the following interventions will be carried out: a. Notification of attending physician and family member/responsible party by nursing staff. b. Notification of dietetics professional by nursing staff. The dietetics professional will assess the resident, document the assessment, and make recommendations in the resident's medical record. During a review of the facility's P&P titled, Change in Condition, Notification of, last reviewed and approved on 1/22/2025, the P&P indicated the facility must immediately inform the resident, consult with the resident's physician and/or nurse practitioner, and notify, consistent with his/her authority, Resident Representative where there is: a significant change in the resident's physical, [NAME], or psychosocial status (that is, a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 44244 Based on observation, interview, and record review, the facility failed to ensure the safe and appropriate use of side rails (SR or bed rail - adjustable, rigid, plastic or metal bars attached to the bed that may be positioned in various locations on the bed; upper or lower, either or both sides) for one of five sampled residents (Resident 145) reviewed under the Accidents care area by failing to: 1. Attempt to use appropriate alternatives prior to installing bilateral (both sides) upper (at the head and shoulder area) SRs. 2. Conduct an assessment including the risk for entrapment (occurs when a resident is caught between the mattress and bed rail or within the bed rail itself) from bilateral upper SRs use. 3. Review the risks and benefits of bilateral upper SRs with the resident or resident representative and obtain informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered). 4. Develop and implement a Care Plan (CP - a written course of action that helps a resident achieve outcomes that improve their quality of life) for the use of SRs. These deficient practices had the potential to result in physical harm from entrapment and death of residents. Cross-reference F656 Findings: During a review of Resident 145's Admission Record, the Admission Record indicated the facility admitted the resident on 10/23/2024 and readmitted the resident on 11/23/2024 with diagnoses that included spinal stenosis (a narrowing of the spinal canal in your lower back that may cause pain or numbness in your legs), radiculopathy (a condition that occurs when a nerve in the spine is damaged or irritated, often called a pinched nerve), cervical region (area at the neck), lack of coordination, and muscle weakness. During a review of Resident 145's Minimum Data Set (MDS - resident assessment tool), dated 11/29/2024, the MDS indicated the resident was able to understand others and was able to make herself understood. The MDS further indicated the resident had impairment on one side of the upper extremities, was dependent on staff for toileting and bathing, and required partial/moderate assistance for personal and oral hygiene. The MDS indicated the resident required substantial/maximal assistance from staff for transferring from the bed to chair, rolling left to right in the bed, and moving from sitting to lying. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 145's Order Summary Report, dated 11/23/2024, the Order Summary Report indicated an order for bed rails as an enabler for turning and repositioning in bed. During a review of Resident 145's Bed Rail Evaluation, dated 11/23/2024, the Bed Rail Evaluation indicated the resident was not able to move upper and lower extremities and the SR recommendation was for no SRs to be used. The evaluation did not indicate any alternatives were attempted prior to the use of SRs and did not indicate an assessment was completed for potential entrapment. The evaluation did not indicate to develop a CP on the use of SRs. During a concurrent observation and interview with Resident 145, on 1/28/2025, at 8:45 a.m., inside Resident 145's room, Resident 145 laid in bed with bilateral upper SRs in the raised position. Resident 145 stated the SRs are always up. During a concurrent observation, interview, and record review with Minimum Data Set Nurse (MDSN) 1 and Registered Nurse (RN) 1, on 1/30/2025, at 8:45 a.m., Resident 145's physician orders, Bed Rail Evaluation, dated 11/23/2024, CPs, and informed consents were reviewed. MDSN 1 entered Resident 145's room and stated the resident had bilateral upper SRs in use. RN 1 stated the process for the use of SRs is to first attempt to use alternatives prior to SRs use, then a safety assessment should be completed, and informed consent should be obtained with the physician's order. RN 1 stated Resident 145's most recent bed rail evaluation indicated the use of SRs was not recommended. RN 1 stated Resident 145 had a physician's order for the use of SRs and the SR evaluation was not completed correctly. RN 1 stated when the SR evaluation was not completed correctly it resulted in the following: no alternatives to SRs were attempted prior to the use of SRs, the resident was not assessed for safety and the risk for entrapment, and informed consent was not obtained. RN 1 stated it was important to attempt alternatives, assess the resident for safety, and obtain consent because SRs can lead to injury of the resident. RN 1 stated CPs are used to provide a resident's care with resident specific interventions and goals. RN 1 stated resident's using SRs should have a CP for the use of SRs. RN 1 stated the importance of the SR CP was to know if resident goals, like remaining free of injury from the use of SRs, were met or not met. RN 1 stated Resident 145 did not have a CP for the use of SRs, but the resident should have had a CP. During a concurrent interview and record review, on 1/31/2025, at 9:30 a.m., with the Director of Nursing (DON), the facility's policy and procedures (P&P) titled, Siderails, last reviewed 1/22/2025, was reviewed. The DON stated there is a process for the use of SRs that includes an assessment to determine the safety of SR use and to explain the risk of the SRs to the resident while obtaining informed consent. The DON stated this process was not followed when the facility used SRs on Resident 145 without a safety assessment, without attempting alternatives, and without obtaining informed consent. The DON stated when the facility P&P was not followed it could have potentially resulted in entrapment of the resident. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Siderails, last reviewed 1/22/2025, the P&P indicated the purpose of the policy was to ensure the safe use of side rails as an assistive device, to aid mobility, or to treat medical symptoms. The Interdisciplinary Team (IDT) will determine whether a resident should be provided with side rails on his/her bed, based on an individual assessment which includes the risk for entrapment. Side rails are only permissible if they are used to treat a resident's medical symptoms or to assist with mobility and transfer of residents. Following admission and/or as a resident's condition necessitates, a licensed nurse and or the IDT attempt at less restrictive approaches and evaluating their effectiveness will be part of the IDT recommendations and review. The licensed nurse will complete the Bedrail Evaluation and develop a Care Plan reflecting the evaluation. The IDT will discuss the risks involved with SRs with the resident and/or the resident's surrogate decision maker and caregivers and describe alternatives that may be safer and feasible. Prior to placing the SRs on the bed, informed consent will be obtained when SR meets the definition of a restraint even when it is also an enabler.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 43455 Based on interview and record review the facility failed to: a. Dispose of medications in a manner that was not retrievable (able to get back) in one (1) of two (2) inspected Medication Rooms (Medication Room Station 2). b. Include the verifying signatures of either the Director of Nursing (DON) or a Registered Nurse (RN) along with Licensed Vocational Nurse (LVN) on the Controlled or Antibiotic Drug Record accountability logs for three (3) of six (6) sampled records awaiting disposal (removal, destroying) in the Controlled Substances (CS - also known as Controlled Drug and Controlled Medications [CD, CM - medications which have a potential for abuse and may also lead to physical or psychological dependence]) locked cabinet. As a result, control and accountability of CS ' s and medications awaiting final disposition (process of returning and/or destroying unused medications) did not follow state and federal regulations and facility policy and procedures. These deficient practices increased the opportunity for medication diversion (the transfer of a medication from a lawful to an unlawful channel of distribution or use), CS diversion, and increased the risk that residents in the facility could have accidental exposure to harmful medications possibly leading to physical and psychosocial harm, and hospitalization . Findings: During a concurrent interview and record review, on 1/30/2025, at 12:00 p.m., with the DON and Assistant Director of Nursing (ADON), the accountability logs for CSs awaiting final disposition in a locked cabinet were reviewed and three Antibiotic or Controlled Drug Record, dated 1/27/2025, did not contain verifying signatures. The DON and ADON stated they were unable to locate the verifying signatures of RN/DON on the three Antibiotic or Controlled Drug Record accountability logs. The DON stated the DON failed to sign the Antibiotic or Controlled Drug Record accountability logs upon receipt of the CSs from the LVNs. The DON and ADON stated they count the CSs with the LVN upon receipt of the accountability log, however they overlooked to sign & date the three logs. The DON stated the DON understood the importance of CS accountability to ensure each CS dose was accounted for until disposed throughout the process of CS accountability. The DON stated it was important to verify and sign these logs to prevent medication diversions and accidental exposure of harmful substances to residents. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview, on 1/30/2025, at 12:35 p.m., with the ADON in Medication Room Station 2, the pharmaceutical waste bin contained a mixture of intact (not damaged or impaired in any way) loose medication tablets and capsules out of their manufacturer packaging, and medications in orange bottles. The ADON stated per facility policy and procedures, medications needed to be disposed of in a manner that the medications could not be retrieved intact (unchanged from original form) by pouring liquid over them to disintegrate (break apart) the medications. The ADON stated the pharmaceutical bin did not contain any liquid to disintegrate the medications, and the medications remained in their original form, allowing for easy access, retrieval and potential re-use. During an interview, on 1/30/2025, at 12:35 p.m., with the DON, the DON stated per facility policy and procedures, medications needed to be disposed of in a manner that the medications could not be retrieved intact by pouring Drug Buster (a liquid that disintegrates the medications, in the pharmaceutical bin). The DON acknowledged the pharmaceutical waste bin contained medications that were disposed in their original manufacturer packaging and as loose tablets and capsules. The DON acknowledged without proper disposal of medications, there is a potential for accidental misuse and diversion of medication, and exposure of harmful substances affecting the safety of all residents and staff. The DON stated the facility failed to destroy the medications found in the pharmaceutical bin in Medication Room Station 2 safely and according to facility policy and state regulations. During a review of the facility ' s policy and procedures (P&P) titled, Controlled Substances, last reviewed 1/22/2025, the P&P indicated The facility complies with all laws, regulations and other requirements related to handling, storage, disposal, and documentation of CM. 7. Waste and/or disposal of CMs are done in the presence of the nurse and a witness who also signs the disposition sheet. 21. Accountability records for discontinued CS are kept with the unused supply until it is destroyed or disposed of as required by applicable law or regulation. During a review of the P&P titled, Discarding and Destroying Medications, last reviewed 1/22/2025, the P&P indicated Medications . are disposed of in accordance with federal, state, and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste and controlled substances. Schedule II, III, and IV (non-hazardous) CS will be disposed of in accordance with the state regulations and federal guidelines regarding disposition of non-hazardous CM. The medication disposition record will contain .: Signature of witnesses. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the P&P titled, Controlled Medication Disposal, last reviewed 1/22/2025, the P&P indicated Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility, in accordance with federal and state laws and regulations. The DON and the Consultant Pharmacist are responsible for the facility ' s compliance with federal and state laws and regulations in the handling of CMs. When a dose of a CM is removed from the container for administration but refused by the resident or not given for any reason .It must be destroyed according to facility policy in the presence of two licensed nurses and the disposal documented on the accountability record .The same process applies to the disposal of unused partial tablets and unused portions of single dose ampules and doses of CS wasted for any reason.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on interview and record review, the facility failed to ensure that residents' drug regimen were free from unnecessary drugs (any drug in excess) for two (2) of four (4) sampled residents (Resident 10 and 141) for unnecessary medication review. 1. Resident 10's duplicate medication orders for the same indication remained as active drugs on the Medication Administration Record (MAR - a record of medications administered to a resident), starting 1/19/2025. 2. Resident 141 did not have monitoring for the side effects (also known as adverse effects - unwanted, uncomfortable, or dangerous effects that a drug may have) of Pradaxa (an anticoagulant [blood thinner] medication used for atrial fibrillation [Afib - irregular, often rapid heart rate that commonly causes poor blood flow]), between 1/1/2025 and 1/30/2025. These deficient practices had the potential to cause Resident 10 and Resident 141 to receive suboptimal (less than the highest standard or quality) care leading to the use of unnecessary medications causing potential side effects and negatively impacting their physical, mental, and psychosocial well-being. Cross-reference F656. Findings: 1. During a review of Resident 10's Admission Record (a document containing demographic and diagnostic information), dated 1/30/2025, the Admission Record indicated Resident 10 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including morbid obesity. During a review of Resident 10's MAR, dated January 2025, printed 1/29/2025, at1:06 p.m., the MAR indicated that Resident 10 was prescribed and had an active order for: 1.) rivaroxaban (a blood thinner medication used for Deep Vein Thrombosis [DVT - a condition that forms blood clots in the body]) 10 milligram (mg - a unit of measure of mass) tablet to be given orally at bedtime at 9:00 p.m. starting 5/28/2024, and 2.) rivaroxaban 10 mg tablet to be given orally at bedtime at 9 p.m. starting 1/19/2025. The MAR indicated that both rivaroxaban 10 mg doses were signed off as administered from the following licensed nurses on the following times/dates: Licensed Vocational Nurse (LVN) 9 - at 9:00 p.m., on 1/20/2025 and 1/21/2025 Registered Nurse (RN) 3 - at 9:00 p.m., on 1/22/2025 and 1/23/2025 LVN 3 -at 9:00 p.m., on 1/24/2025 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN 10 - at 9:00 p.m., on 1/25/2025, 1/26/2025, 1/27/2025, and 1/28/2025 2. During a review of Resident 141's Admission Record, the Admission Record indicated Resident 141 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including Afib. During a review of Resident 141's Order Summary Report, dated 8/22/2024, the Order Summary Report indicated Resident 141 was prescribed Pradaxa 150 mg to give one tablet by mouth every 12 hours for Afib, starting 12/18/2024. During a review of Resident 141's MAR, dated January 2025, the MAR indicated Resident 141 was prescribed Pradaxa 150 mg to give one tablet by mouth every 12 hours for Afib, at 9:00 a.m. and 9:00 p.m. The MAR did not contain documentation for the monitoring of side effects of Pradaxa between 1/1/2025 and 1/30/2025. During a concurrent interview and record review, on 1/30/2025, at 9:30 a.m., with the Director of Nursing (DON), Resident 10's MAR, dated January 2025, was reviewed and the DON stated that Resident 10 had two active orders for rivaroxaban 10 mg starting 1/19/2025. The DON stated the MAR showed both 10 mg doses were documented as given between 1/20/2025 and 1/28/2025. The DON stated that this was due to documentation error and Resident 10 did not receive both doses, since Resident 10 only had one (1) medication supply from the pharmacy for rivaroxaban. The DON stated the physician order on 5/28/2024 needed to be discontinued when a new order for rivaroxaban was prescribed on 1/19/2025. The DON stated that Resident 10 could potentially receive both doses of rivaroxaban if the medication was available and lead to harm by causing excessive bleeding and possibly death. The DON stated the facility failed to identify the duplicate order on the January 2025 MAR starting 1/19/2025. During a concurrent interview and record review, on 1/30/2025, at 10:08 a.m., with the DON, Resident 141's Care Plan, dated 12/31/2024, was reviewed and the DON stated Resident 141's Care Plan indicated Resident 141 was at risk for complications from Pradaxa, and to monitor for active bleeding. The DON stated monitoring for bleeding would be documented on the MAR and the DON was unable to locate documentation for monitoring for bleeding related to use of Pradaxa for Resident 141 between 1/1/2025 and 1/30/2025. The DON stated that monitoring for bleeding with Pradaxa use was important to ensure Resident 141 does not have bleeding that was unnoticed, which may harm the resident and require hospitalization . During a review of the facility's policy and procedures (P&P) titled, Physician Orders, last reviewed 1/22/2025, the P&P indicated that the Medical Records Department will verify that physician orders are complete, accurate and clarified as necessary. During a review of the facility's P&P titled, Medication Utilization and Prescribing - Clinical Protocol, last reviewed 1/22/2025, the P&P indicated: 4. The consultant pharmacist should use the monthly and interim drug regimen review to help identify potentially problematic medications, including medication regimens that are not supported based on clinical signs and symptoms. 3. The staff and practitioners in collaboration with the consultant pharmacist will take into account medication-related issues such as .effects of medication combinations and drug-drug interactions. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Medication and Treatment Orders, last reviewed 1/22/2025, the P&P indicated Orders for medications and treatments will be consistent with principles of safe and effective order writing.

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	056113	A. Building B. Wing	01/31/2025

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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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on interview and record review, the facility failed to ensure two (2) of five (5) sampled residents (Resident 21 and 358) drug regimen was free from unnecessary (any medication in excessive dose, excessive duration, without adequate monitoring) psychotropic (a medication that affects brain activity associated with mental processes and behavior) medications by failing to ensure: 1. Resident 21 had a specific, measurable target behavior related to the use of sertraline (an antidepressant [against depression] medication used for depression or bipolar disorder), starting 12/7/2024. 2. Quetiapine fumarate (an antipsychotic [a class of medication used to treat psychiatric disorders]) and sertraline HCl (a medication to treat depression [persistent feelings of sadness)] were prescribed, administered, and monitored for specific measurable behavioral manifestations for Resident 358. These deficient practices had the potential to result in unnecessary medication administration and placed Resident 21 and 358 at risk for significant adverse effects (unwanted, unintended result of medications) from the use of unnecessary antipsychotic medications, including confusion, dizziness, and injuries from falls, resulting in the impairment or decline of residents' mental, physical condition, functional, and psychosocial status. Findings: 1.a. During a review of Resident 21's Admission Record (a document containing demographic and diagnostic information,) dated 1/30/2025, the Admission Record indicated Resident 21 was originally admitted to the facility on [DATE] with a diagnosis that included bipolar. During a review of Resident 21's Order Summary Report, dated 1/30/2025, the report indicated Resident 21 was prescribed sertraline 50 milligram (mg - a unit of measure of mass) one (1) tablet by mouth daily for depression manifested by sadness, starting 12/7/2024. During a review of Resident 21's Medication Administration Record ([MAR] - a record of medications administered to residents) for January 2025, the MAR indicated Resident 21 was prescribed sertraline 50 mg one (1) tablet by mouth to be given daily for depression manifested by sadness, at 9 a.m. During a review of Resident 21's Minimum Data Set (MDS - resident assessment tool), dated 12/13/2024, the MDS indicated Resident 21 was cognitively (mental action or process of acquiring knowledge and understanding) intact. Resident 21's MDS indicated zero (0) symptoms of having Little interest or pleasure in doing things and zero (0) symptoms in Feeling down, depressed, or hopeless. Resident 21's MDS indicated Resident 21 was taking antidepressants. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent record review and interview on 1/30/2025 at 2:12 p.m., with the Director of Nursing (DON,) the DON reviewed Resident 21's MDS and MAR. The DON stated the MDS did not indicate that Resident 21 was depressed, and the January 2025 MAR indicated the sertraline order did not include monitoring for a specific type of behavior and condition. The DON stated sadness was not considered a behavior but rather an emotion. The DON stated the monitoring of sadness for sertraline use was unclear and open to interpretation by different licensed nurses. The DON stated not having specific behavior and condition monitoring could result in inaccurate assessment by the physician for the effectiveness of Resident 21's sertraline therapy. The DON stated that the facility failed to have individualized, person-centered care by monitoring a non-specific behavior for Resident 21, potentially resulting in the use of unnecessary psychotropic medication. 44244 1.b. During a review of Resident 358's Admission Record, the Admission Record indicated the facility admitted the resident on 1/9/2025 with diagnoses that included depression, dementia (a progressive state of decline in mental abilities), and a history of falls. During a review of Resident 358's MDS dated [DATE], the MDS indicated the resident sometimes was able to understand others and sometimes was able to make himself understood. The MDS further indicated the resident was dependent on staff for toileting, showering, dressing, and transferring from the bed to the toilet or shower. The MDS indicated the resident was taking antipsychotic and antidepressant medication. During a review of Resident 358's Order Summary Report, the report indicated the following orders: - Quetiapine fumarate oral tablet 50 mg, give one tablet by mouth three times a day for agitation, dated 1/9/2025. - Anti-psychotic: monitor episodes of agitation every shift, dated 1/9/2025. - Sertraline HCl oral tablet 100 mg , give one tablet by mouth one time a day for depression manifested by unhappiness, dated 1/9/2025. - Anti-depressant: monitor episodes of unhappiness every shift, dated 1/9/2025. During a review of Resident 358's Care Plan (CP) titled, Resident is at risk for complications related to the use of psychotropic drugs . Medication: Sertraline . Quetiapine ., initiated on 1/10/2025, the CP indicated a goal that the resident will have the smallest most effective dose without side effects. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/30/2025 at 2:21 p.m., with Minimum Data Set Coordinator 1 (MDSC 1), MDSC 1 reviewed Resident 358's physician orders and Medication Administration Record. MDSC 1 stated psychotropic medications affect the mind and behavior of residents. MDSC 1 stated psychotropics are considered high risk medications for the elderly because there was the potential for side effects like death of the resident from polypharmacy (the regular use of five or more medications at the same time and is common in older adults). MDSC 1 stated psychotropic medication use must be monitored to ensure the resident has behaviors that warrant the use of the medication. MDSC 1 stated the goal is to eliminate the medication or lower the dose to prevent adverse effects. MDSC 1 stated Resident 358's quetiapine fumarate was ordered for the behavior manifestation of agitation. MDSC 1 stated agitation is very general and is not descriptive of a specific behavior to monitor like outbursts or restlessness. MDSC 1 stated Resident 358's sertraline was prescribed with the behavior manifestation of unhappiness. MDSC 1 stated unhappiness is very general and is not descriptive of a specific behavior like verbalization of sadness. MDSC 1 stated the admitting nurse or the interdisciplinary team should have clarified with the physician to indicate specific behavioral manifestations to monitor, but they did not. During a concurrent interview and record review on 1/31/2025 at 9:30 a.m. with the DON, the DON reviewed the facility policy and procedures regarding psychotropic medications. The DON stated agitation and unhappiness are not specific behavioral manifestations for the use of psychotropics. The DON stated there must be specific, targeted behaviors to monitor and evaluate for the possibility of a gradual dose reduction (GDR) of a resident's psychotropic medication. The DON stated GDRs are important to lessen the chance of side effects from unnecessary medications. The DON stated when unnecessary psychotropic medications are administered there is a high risk for side effects like falls that may result in fractures. The DON stated the facility policy was not followed when Resident 358's psychotropic medications were not ordered with specific behavioral manifestations to monitor. During a review of facility Policy and Procedures (P&P,) titled Psychotropic Medication Use, by SNF Clinic, last revised July 2022, the P&P indicated: Residents will not receive medications that are not clinically indicated to treat a specific condition. 1. A Psychotropic medication is any medication that affects brain activity associated with mental processes and behavior. 2. Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: a. Anti-psychotics b. Anti-depressants 3. Psychotropic medication management includes: a. Indications for use d. Adequate monitoring for efficacy (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Residents who have not used psychotropic medications are not prescribed or given these medications unless it is determined to be necessary to treat a specific condition that is diagnosed and documented in the clinical record. 8. Consideration of the use of any psychotropic medication is based on a comprehensive review of the resident. This includes evaluation of the resident's signs and symptoms to identify underlying causes. 3. When determining whether to initiate, modify, or discontinue medication therapy, the IDT conducts an evaluation of the resident. The evaluation will attempt to clarify whether: signs and symptoms are clinically significant enough to warrant medication therapy. During a review of the facility's P&P titled Psychotropic Medication Use, by Skilled Nursing Pharmacy, with an effective date June 2021, the P&P indicated that A psychotropic drug is any medication that affects brain activities associated with mental processes and behavior, which includes but is not limited to antipsychotics, anxiolytics, hypnotics and antidepressants. The Facility should comply with the State Operations Manual, and all other Applicable Law relating to the use of psychoactive medications, including gradual dose reductions. 1c. Staff should become familiar with .the resident to .reduce behavioral symptoms and/or distress, types and the consequences of behaviors exhibited by the resident and interventions that maybe indicated for a specific behavior type. 3. Psychotropic medications to treat behaviors will be used appropriately to address specific underlying medical or psychiatric causes of behavioral symptoms.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five (5) percent (%). Three (3) medication errors out of 29 total opportunities contributed to an overall medication error rate of 10.35% affecting two (2) of five (5) residents observed for medication administration (Resident 109 and 257). The medication errors were as follows: 1. Resident 257 did not receive a form of aspirin (a medication used to treat peripheral vascular disease [PVD - a condition that affects blood vessels] and Deep Vein Thrombosis [DVT - a condition that forms blood clots in the body] in those with atrial fibrillation [an irregular, fast heart rate]) as ordered by Resident 257's physician. 2. Resident 109 received metformin (a medication used to treat high blood sugar levels) and aspirin at a different time than ordered by Resident 109's physician. These failures had the potential to result in Resident 257 and Resident 109 to experience medication adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) and had the potential to result in residents' health and well-being to be negatively impacted. Findings: 1. During a review of Resident 257's Admission Record, the Admission Record indicated the resident was originally admitted to the facility on [DATE] with diagnoses including atrial fibrillation. During a review of Resident 257's Order Summary Report, dated 1/28/2025, the Order Summary Report indicated Resident 109 was prescribed aspirin 81 milligram (mg - a unit of measure of mass) enteric coated (EC - a form of aspirin that is designed to slowly release medication) tablet once a day for DVT prophylaxis (prevention) starting 1/25/2025. During a review of Resident 257's Medication Administration Record (MAR - a record of mediations administered to residents), dated January 2025, the MAR indicated Resident 257 was prescribed aspirin 81 mg EC tablet to be given once a day orally for DVT prophylaxis at 9:00 a.m. During an observation, on 1/28/2025, at 8:59 a.m., in Medication Cart Station 1, Licensed Vocational Nurse (LVN) 5 administered aspirin 81 mg chewable tablet to Resident 257. Resident 257 swallowed the aspirin tablet with glass of juice. During an interview, on 1/28/2025, at 1:15 p.m., with LVN 5, LVN 5 stated that LVN 5 administered aspirin 81 mg chewable tablet during the morning medication administration at 8:59 a.m. to Resident 257. LVN 5 stated that LVN 5 failed to follow the physician orders to administer aspirin 81 mg EC tablet. LVN 5 stated this was considered a medication error, and that there was a risk for stomach irritation to 257 when the EC form was not given. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 109's Admission Record, the Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Diabetes Mellitus 2 (DM2 - a condition where there are high blood sugar levels.) During a review of Resident 109's Order Summary Report, dated 1/28/2025, the Order Summary Report indicated Resident 109 was prescribed aspirin 81 mg once a day for PVD starting 6/13/2024, and metformin 500 mg twice a day for diabetes starting 6/6/2024. During a review of Resident 109's MAR, dated January 2025, the MAR indicated Resident 109 was prescribed aspirin 81 mg to be given once a day orally for PVD at 8:00 a.m., and metformin 500 mg to be given twice a day orally for diabetes at 7:00 a.m. and 5:00 p.m. During an observation, on 1/28/2025, at 9:40 a.m., in Medication Cart Station 2, LVN 1 administered aspirin 81 mg tablet and metformin 500 mg tablet to Resident 109. Resident 109 swallowed the aspirin and metformin tablet with glass of water. During an interview, on 1/28/2025, at 12:45 p.m., with LVN 1, LVN 1 stated that LVN 1 administered aspirin 81 mg tablet and metformin 500 mg tablet during the morning medication administration at 9:40 a.m. to Resident 109. LVN 1 acknowledged the physician's order specified to administer metformin at 7:00 a.m. and aspirin at 8:00 a.m. LVN 1 stated, per facility policy, there was a 60-minute window for medication administration and LVN 1 administered the metformin and aspirin later than that timeframe. LVN 1 stated these were considered medication errors. During an interview, on 1/30/2025, at 2:18 p.m., with the Director of Nursing (DON), the DON stated LVN 5 failed to administer aspirin 81 mg EC tablet to Resident 109, and LVN 1 failed to administer metformin 500 mg tablet and aspirin 81 mg tablet to Resident 257 at the scheduled time, according to the physician orders. The DON stated licensed nurses should follow facility medication administration guidelines to ensure physician orders are followed and the right medications at the right times are administered to residents. The DON stated Resident 109 may be at risk for developing stomach irritation from receiving aspirin 81 mg chewable tablet, and Resident 257 may be at risk of stomach irritation from receiving the metformin at 9:40 a.m. without a meal. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, last reviewed 1/22/2025, the P&P indicated Medications are administered in a safe and timely manner, and as prescribed. 4. Medications are administered in accordance with prescriber orders, including any required time frame. 7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified. 9. The individual administering the medication checks to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. During a review of the facility's P&P titled, Medication Errors, last reviewed 1/22/2025, the P&P indicated: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Medication Error means the administration of medication: At the wrong time Which is not currently prescribed.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors (means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards) for three (3) of three (3) sampled residents (Resident 51, 129 and 137) investigated for insulin (a hormone that lowers the level of glucose [a type of sugar] in the blood) use by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous ([SQ] -beneath the skin) insulin administration sites. This deficient practice increased the risk that Residents 51, 129 and 137 could experience adverse effects (unwanted, unintended result) from same site subcutaneous administration of insulin such as lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Cross Reference F658 Findings: 1. During a review of Resident 51's Admission Record (a document containing demographic and diagnostic information,) the admission record indicated the facility originally admitted Resident 51 on 3/5/2019 and readmitted the resident on 6/11/2024, with diagnoses including type 2 diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and generalized muscle weakness. During a review of Resident 51's Minimum Data Set (MDS - a resident assessment tool) dated 11/9/2024, the MDS indicated Resident 51 had an intact cognition (mental action or process of acquiring knowledge and understanding) and required supervision or touching assistance with eating; partial /moderate assistance with personal hygiene and rolling left and right; substantial/maximal assistance with upper body dressing, lower body dressing, , and sit to lying/lying to sitting; total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 51 received insulin. During a review of Resident 51's History and Physical (H&P) dated 6/19/2024, the H&P indicated Resident 51 did not have the capacity to understand and make decisions. During a review of Resident 51's Order Summary Report, the Order Summary Report indicated the following physician's orders dated: - 6/11/2024: Insulin glargine-yfgn (Lantus -a long-acting insulin) subcutaneous (SQ - under the skin]) solution pen-injector 100 unit per ml (unit/ml - a unit of measurement) inject 15 units SQ at bedtime for DM. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 6/12/2024 to 10/31/2024; 10/31/2024 to 12/6/2024: Insulin lispro MUV 100 unit/ml vial. Inject SQ before meals and at bedtime for DM. Inject as per sliding scale: if 140 - 199 = 1; < 70 and conscious glucogel (a gel form of glucose which provides a direct source of sugar 1pack or 4 ounce ([oz - a unit of measurement]) juice, if unconscious, give glucagon intramuscular ([IM - into the muscle tissue]) one time and call MD; 200 - 249 = 2; 250 - 299 = 3; 300 - 349 = 4; 350 - 400 = 5. If blood sugar is greater than 400 mg per deciliter (dl - a unit of measurement) administer 5 units and Call MD. - 12/6/2024: INSULIN LISPRO MUV 100 UNIT/1ML VIAL Inject SQ before meals and at bedtime for DM inject within 15 mins before meal or with first bite of meal. Inject as per sliding scale (insulin dosing plan whereby the amount of insulin administered depends on the resident's blood sugar level): if 140 - 199 = 1; < 70 and conscious glucogel 1pack or 4 oz juice, if unconscious, glucagon IM one time and call MD; 200 - 249 = 2; 250 - 299 = 3; 300 - 349 = 4; 350 - 400 = 5. If blood sugar is greater than (> - a unit of measurement) 400 mg per deciliter (dl - a unit of measurement) = give 5 units and call MD. During a concurrent interview and record review on 1/30/2025 at 11:15 a.m., Resident 51's Order Summary Report, MAR, Location of Administration Report for 12/2024 and 1/2025 was reviewed with LVN 2, LVN 2 verified Resident 51 had a physician's order for insulin lispro and insulin glargine and were administered as follows: - Insulin glargine-yfgn SQ solution pen-injector 100 unit/ml 12/05/24 9:30 p.m. SQ Abdomen - LUQ 12/06/24 9:27 p.m. SQ Abdomen - LUQ 12/12/24 9:13 p.m. SQ Abdomen - LUQ 12/13/24 9:23 p.m. SQ Abdomen - LUQ 12/19/24 10:08 p.m. SQ Arm - left 12/20/24 8:59 p.m. SQ Arm - left 12/21/24 9:21 p.m. SQ Abdomen - RLQ 12/22/24 9:50p.m. SQ Abdomen - RLQ 12/26/24 9:24 p.m. SQ Abdomen - LUQ 12/27/24 9:34 p.m. SQ Abdomen - LUQ 1/16/25 9:00 p.m. SQ Abdomen - LUQ 1/17/25 10:00 p.m. SQ Abdomen - LUQ 1/18/25 8:23 p.m. SQ Abdomen - LUQ (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/19/25 8:56 p.m. SQ Abdomen - RLQ 1/20/25 9:37 p.m. SQ Abdomen - RLQ 1/21/25 9:09 p.m. SQ Abdomen - left lower quadrant (LLQ) 1/22/25 9:43 p.m. SQ Abdomen - LLQ - Insulin lispro MUV 100 unit/ml vial: 12/06/24 11:28 a.m. SQ Arm - left 12/07/24 11:26 a.m. SQ Arm - left LVN 2 stated insulin administration sites should be rotated per standards of practice and manufacturer's guidelines. LVN 2 verified Resident 51's MAR indicated the insulin administration sites were not rotated. LVN 2 stated Resident 51's insulin administration sites should have been rotated per the manufacturer's guidelines and standards of practice to prevent pain, redness, irritation, and bumps or lumps on the resident's skin. LVN 2 stated not rotating the administration sites can be considered a medication error by not following the manufacturer's guideline and standards of practice. During an interview on 1/30/2025 at 3 p.m. with DON, the DON stated the administration sites of insulin should be rotated per as indicated in the manufacturer's guideline and according to standards of practice to prevent complications such as bruising, and lipodystrophy. The DON stated Resident 51's insulin administration site should have been rotated as it placed the resident at risk for pain bruising, lipodystrophy, and amyloidosis. The DON stated not rotating insulin administration sites can be considered a medication error due to not following the standards of practice and manufacturer's guideline. During a review of the facility's policy and procedure (P&P) tilted, Insulin Administration, last reviewed 1/25/2025, the P&P indicated a purpose to provide guidelines for the safe administration of insulin to residents with diabetes. Select an injection site. The P&P further indicated: a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility provided manufacturer's guideline on Lantus (insulin glargine, last revised on 6/2023, the manufacturer's guideline indicate to administer Lantus SQ into the abdominal area, thigh, or deltoid, and rotate injection sites within the same region from one injection to the next to reduce the risk of lipodystrophy and localized cutaneous amyloidosis. Do not inject into the areas of lipodystrophy or localized cutaneous amyloidosis. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility provided manufacturer's guideline on, Insulin Lispro Kwikpen, last reviewed on 1/25/2025, the manufacturer's guideline indicated to change or rotate injection sites within the area with each dose to reduce the risk of getting lipodystrophy (pits in skin or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. - Do not the exact same spot for each injection. - Do not inject where the skin has pits, is thickened, or has lumps. - Do not inject where the skin is tender, bruised, scaly or hard, or into scars or damaged skin. 2. During a review of Resident 137's Admission Record, the admission record indicated the facility originally admitted Resident 137 on 5/21/2024 and readmitted the resident on 1/9/2025, with diagnoses including congestive heart failure (CHF - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), DM2, and generalized muscle weakness. During a review of Resident 137's MDS dated [DATE], the MDS indicated Resident 137 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living ADLs. The MDS indicated Resident 137 received insulin. During a review of Resident 137's H&P dated 1/12/2025, the H&P indicated Resident 137 did not have the capacity to understand and make decisions. During a review of Resident 137's Order Summary Report, the Order Summary Report indicated the following physician's orders dated: - 12/1/2024 to 12/10/2025; 12/10/2024 to 1/9/2025: Insulin lispro (a short acting insulin) injection solution inject SQ before meals and at bedtime for DM 2 to inject 15 minutes before meals or with first bite of the meal. Inject as per sliding scale: if 71 - 150 = 0 ; less than (< - a unit of measurement) 70 if patient is conscious, give four (4) oz of juice. If unconscious, give glucagon 1 mg IM one time. Notify MD; 151 - 200 = 1 unit; 201 - 250 = 2; 251 - 300 = 3; 301 - 350 = 4; 351 - 400 = 6; above 401 = 8. - 1/9/2025: Insulin lispro injection solution inject SQ before meals and at bedtime for DM 2. Inject as per sliding scale: if 151 - 200 = 1; if blood sugar is < 70 and conscious give 4 oz of juice. If unconscious give glucagon 1mg IM one time and notify MD; 201 - 250 = 2; 251 - 300 = 3; 301 - 350 = 4; 351 - 400 = 6 if blood sugar above 400, give 8 units and notify MD for DM 2. - 9/6/2024 to 12/1/2024: Insulin glargine (Lantus - a long-acting insulin) SQ solution 100 unit/ml inject 50 units SQ two times a day for DM 2. - 1/9/2025: Lantus solostar subcutaneous solution pen-injector 100 unit/ml. inject 40 units SQ two times a day for DM 2. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/30/2025 at 11 a.m., Resident 137's Order Summary Report, MAR, Location of Administration Report for 12/2024 and 1/2025 was reviewed with Licensed LVN 2, LVN 2 verified Resident 137 had a physician's order for insulin lispro and Lantus and were administered as follows: - Insulin lispro injection solution: 12/02/24 9:02 p.m. SQ Arm - right 12/03/24 6:06 a.m. SQ Arm - right 12/04/24 5:07 p.m. SQ Abdomen - left upper quadrant (LUQ) 12/04/24 9:14 p.m. SQ Abdomen - LUQ 12/11/24 12:22 p.m. SQ Arm - left 12/11/24 6:06 p.m. SQ Arm - left 12/11/24 9:11 p.m. SQ Arm - right 12/12/24 6:11 a.m. SQ Arm - right 12/14/24 8:24 p.m. SQ Abdomen - LUQ 12/15/24 5:26 p.m. SQ Abdomen - LUQ 12/18/24 11:46 a.m. SQ Abdomen - right lower quadrant (RLQ) 12/18/24 4:30 p.m. SQ Abdomen - RLQ 1/22/25 4:36 p.m. SQ Arm - right 1/22/25 9:22 p.m. SQ Arm - right 1/23/25 5:59 a.m. SQ Arm - left 1/23/25 11:50 a.m. SQ Arm - left 1/24/25 6:16 a.m. SQ Arm - left - Lantus solostar SQ solution pen-injector 100 unit/ml 1/19/25 10:47 a.m. SQ Abdomen - RLQ 1/19/25 9:12 p.m. SQ Abdomen - RLQ 12/18/24 9:00 p.m. SQ Abdomen - LUQ (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/19/24 9:33 p.m. SQ Abdomen - LUQ LVN 2 stated insulin administration sites should be rotated per standards of practice and manufacturer's guidelines. LVN 2 verified Resident 137's MAR indicated the insulin administration sites were not rotated. LVN 2 stated Resident 137's insulin administration sites should have been rotated per the manufacturer's guidelines and standards of practice to prevent pain, redness, irritation, and bumps or lumps on the resident's skin. LVN 2 stated not following manufacturer's guideline and standards of practice of rotating insulin administration sites can be considered a medication error. During an interview on 1/30/2025 at 3 p.m. with DON, the DON stated the administration sites of insulin should be rotated per as indicated in the manufacturer's guideline and according to standards of practice to prevent complications such as bruising, and lipodystrophy. The DON stated Resident 137's insulin administration site should have been rotated as it placed the resident at risk for pain bruising, lipodystrophy, and amyloidosis. The DON stated not rotating insulin administration sites can be considered a medication error due to not following the standards of practice and manufacturer's guideline. During a review of the facility's policy and procedure (P&P) tilted, Insulin Administration, last reviewed 1/25/2025, the P&P indicated a purpose to provide guidelines for the safe administration of insulin to residents with diabetes. Select an injection site. The P&P further indicated: a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility provided manufacturer's guideline on Lantus (insulin glargine, last revised on 6/2023, the manufacturer's guideline indicate to administer Lantus SQ into the abdominal area, thigh, or deltoid, and rotate injection sites within the same region from one injection to the next to reduce the risk of lipodystrophy and localized cutaneous amyloidosis. Do not inject into the areas of lipodystrophy or localized cutaneous amyloidosis. During a review of the facility provided manufacturer's guideline on, Insulin Lispro Kwikpen, last reviewed on 1/25/2025, the manufacturer's guideline indicated to change or rotate injection sites within the area with each dose to reduce the risk of getting lipodystrophy (pits in skin or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. - Do not the exact same spot for each injection. - Do not inject where the skin has pits, is thickened, or has lumps. - Do not inject where the skin is tender, bruised, scaly or hard, or into scars or damaged skin. 43455 3. During a review of Resident 129's Admission Record dated 1/30/2025, indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including DM2. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 129's Order Summary Report, dated 1/30/2025, indicated Resident 129 was prescribed Regular (short-acting insulin) insulin to inject per sliding scale, SQ before meals and at bedtime related to DM2, starting 4/15/24. During a review of Resident 129's Medication Administration Record ([MAR] - a record of mediations administered to residents) for January 2025, the MAR indicated Resident 129 was prescribed Regular insulin to inject per sliding scale SQ before meals and at bedtime related to DM2, at 6:30 a.m., 11:30 a.m., 4:30 p. m. and 9 p.m. During the same review, the MAR indicated Regular Insulin was administered SQ by the following licensed vocational nurse (LVN)s, on the following days, times, and sites: 1/12/25 two (2) un at 11:30 a.m. on left arm by LVN 6 1/12/25 two (2) un at 4:30 p.m. on left arm by LVN 7 1/12/25 two (2) un at 9 p.m. on left arm by LVN 7 1/16/25 two (2) un at 11:30 a.m. on left arm by LVN 6 1/16/25 two (2) un at 9 p.m. on left arm by LVN 8 During a concurrent interview and record review on 1/30/2025 at 2:18 p.m., with the Director of Nursing (DON,) the DON reviewed Resident 129's MAR for January 2025. The DON stated that Resident 129's MAR indicated there were instances where the insulin administration sites were not rotated by several licensed nurses, as expected by facility policy, standard of practice and manufacturer guidelines. The DON stated the failure of the licensed nurses to rotate insulin administration sites could cause harm to Resident 129 by causing lipodystrophy (skin abnormalities such as lumps in the skin or thickened skin) at the repeated administration sites. The DON stated not rotating insulin administration sites was considered a significant medication error. During a review of the facility's policy and procedure (P&P) tilted, Insulin Administration, last reviewed 1/25/2025, the P&P indicated a purpose to provide guidelines for the safe administration of insulin to residents with diabetes. Select an injection site. The P&P further indicated: c. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel. d. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of facility provided manufacturer's guide Highlights of Prescribing Information for Humulin R (brand name for Regular insulin) dated June 2023, the guide indicated to Rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis (skin with lumps).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 43455 Based on observation, interview, and record review the facility failed to: 1. Store seven (7) ipratropium with albuterol (a combination medication used to treat and prevent shortness of breath) inhalation solutions in the foil pack (package made of foil protecting the inhalation solution from light and degradation) for Resident 72, in accordance with manufacturer's requirements in one (1) of four (4) inspected medication carts (Medication Cart Station 1 T2). 2. Remove and discard from use one (1) expired eye drop medication bottle for Residents 115 in accordance with manufacturer's requirements in one (1) of four (4) inspected medication carts (Medication Cart Station 2 T). 3. Store or label one (1) insulin (medication used to regulate blood sugar levels) Humulin R (short-acting insulin) vial for Resident 258, in accordance with manufacturer's requirements in one (1) of four (4) inspected medication carts (Medication Cart Station 1 T2). 4. Remove and discard from use two (2) open Aplisol (also known as Tubersol - medication used to diagnose tuberculosis [infection in the lungs]) vials for facility stock, in accordance with manufacturer's requirements and facility policy and procedures in one (1) of two (2) inspected Medication Rooms (Medication Room Station 1). These deficient practices increased the risk that Residents 72, 115 and 258 could receive medication that had become ineffective or toxic due to improper storage or labeling, possibly leading to health complications resulting in hospitalization or death. Findings: During a concurrent observation and interview, on 1/29/2025, at 11:10 a.m., in Medication Cart Station 1 T2, with Licensed Vocational Nurse (LVN) 4, the following medications were found either stored in a manner contrary to their respective manufacturer's requirements, not labeled with an open date as required by their respective manufacturer's specifications, or stored and labeled contrary to facility policies: 1. One (1) open ipratropium with albuterol combination inhalation solution foil pouch for Resident 72, was found stored at room temperature and labeled with a date indicating inhalation solution was removed from foil pouch on 1/5/2025. Seven (7) inhalation solutions were stored outside the foil pouch. The manufacturer's product storage and labeling indicated opened foil pouches of ipratropium with albuterol inhalation solutions should always be stored in the foil pouch at room temperature between 36 and 77 degrees Fahrenheit and used or discarded within two weeks of being removed from foil pouch. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. One (1) unopened insulin Humulin R vial for Resident 258 was found stored at room temperature without a date indicating when storage at room temperature began. The label on the prescription bottle indicated to discard unused medication after 31 days. The manufacturer's product labeling indicated unopened Humulin R vials should be stored in the refrigerator room between 36 and 46 degrees Fahrenheit and discarded after 31 days once stored at room temperature. LVN 4 stated the ipratropium with albuterol inhalation solution foil pack for Resident 72 was opened and seven (7) inhalation solutions were stored outside the foil pouch in Medication Cart Station T2 with a date indicating the pouch was opened on 1/5/2025. LVN 4 stated according to the manufacturer guidelines the inhalation vials needed to remain in the foil pouch or when stored outside the pouch discarded within two (2) weeks. LVN 4 stated seven (7) ipratropium with albuterol inhalations were considered expired after 1/19/2025. LVN 4 stated giving expired ipratropium with albuterol can be ineffective in treating the shortness of breath for Resident 72, exacerbate (make worse) the situation leading to stoppage of breathing. LVN 4 stated seven (7) the ipratropium with albuterol inhalation vials for Resident 72 should be discarded from Medication Cart Station 1 T2. LVN 4 stated Resident 258's Humulin R vial was stored at room temperature and not opened and should have either been stored in the refrigerator until opened or labeled with a date when storage at room temperature began. LVN 4 stated it was unknown when the Humulin R vial was stored at room temperature therefore unknown when it would expire and need to be discarded. LVN 4 stated open multi-dose (containing more than one dose) medications like insulins are usually good for 28 days and lose potency (effectiveness) and expire beyond that date, and, if not labeled, the expired insulin can be used in error. LVN 4 stated the Humulin R vial needed to be discarded and replaced with a new one from pharmacy to ensure expired insulin was not administered in error to Resident 258. LVN 4 stated administering expired insulin will not be effective in treating residents blood sugar levels and can harm Resident 258 by causing high blood sugar levels leading to coma (a life-threatening complication that can result from very high blood sugar or very low blood sugar levels) and hospitalization . During a concurrent observation and interview, on 1/29/2025, at 11:24 a.m., in Medication Cart Station 2 T, with LVN 2, the medication below was found either stored in a manner contrary to their respective manufacturer's requirements, not labeled with an open date as required by their respective manufacturer's specifications, or stored and labeled contrary to facility policies: One open dorzolamide (a medication used to decrease pressure in the eye caused by glaucoma [type of eye disease]) eye drop bottle for Resident 115 was found stored at room temperature and labeled with a date indicating use began on 12/27/2024. The label on the prescription bottle indicated to discard unused portion after 28 days. LVN 2 stated the dorzolamide eye drop bottle for Resident 115 was opened on 12/27/2024 and according to the label on the bottle it needed to be discarded after 28 days, which would be on 1/25/2025. LVN 2 stated the dorzolamide eye bottle for Resident 115 was considered expired, and administering expired eye drops would not be effective in treating Resident 115's eye condition as the medication had lost potency and can potentially lead to eye infections as the bottle was no longer sterile beyond the 28 days. (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 concurrent observation and interview, on 1/3/2025, at 12:15 p.m., with Registered Nurse (RN) 1, in Medication Room Station 1, the medication below was found either expired and not discarded, or stored contrary to their respective manufacturer's specifications and facility policies and procedures: Two (2) open Aplisol multi-dose vial for facility stock was found stored in the refrigerator and not labeled with a date indicating when use began. The manufacturer's product storage and labeling indicated Aplisol vials should be stored in the refrigerator between 36 and 46 degrees Fahrenheit and used or discarded from use within 30 days of opening the vial. RN 1 stated two (2) Aplisol vial stored in the refrigerator in Medication Room Station 1 were opened, used, and not labeled with a date indicating when use began. RN 1 stated open Aplisol vials were good for 30 days. RN 1 stated Aplisol vials need to be labeled with a date when first used to know when to discard and not administer expired Aplisol to residents in error. RN 1 stated administering expired Aplisol to residents may result in inaccurate results (either false negative or false positive) and therefore lead to providing the incorrect treatment to residents. RN 1 stated both vials were considered expired and needed to be removed from the refrigerator and placed in the expired medication bin to be disposed of and not accidentally used for residents. During an interview, on 1/30/2025, at 2:18 p.m., with the Director of Nursing (DON), the DON stated that ipratropium with albuterol inhalation vials needed to be discarded after two (2) weeks when stored outside the foil pack, unopened insulin Humulin R vials needed be stored in the refrigerator or labeled with a date when stored at room temperate, and eye drop bottles removed from medication carts are discarded after 28 days of use. The DON stated medications that are not stored according to manufacturer guidelines were considered expired. The DON stated expired medications have lost their potency and will not be effective in treating a resident's condition. The DON stated that several licensed nurses failed to remove expired dorzolamide bottle for Resident 115 from Medication Cart Station 2 T, store ipratropium with albuterol inhalation vials for Resident 72 inside the foil pouch, and label Humulin R vial with an open date for Resident 258 in Medication Cart Station 1 T2, according to facility and manufacturer guidelines. The DON stated these failures could potentially lead to the administration of expired medication to residents. The DON stated administering expired ipratropium with albuterol to Resident 72 will not treat the shortness of breath, exacerbating (making worse) the shortness of breath potentially leading to stoppage of breathing and hospitalization . The DON stated administering expired eye drop to Resident 115 will not be effective in treating the resident's eye condition and potentially cause eye infections. The DON stated administering expired insulin will not be effective in controlling blood sugar levels and can harm Resident 258 by causing high or low blood sugar levels, leading to coma and hospitalization . The DON stated that two (2) Aplisol vial were opened and not labeled with a date when use began and stored in the medication refrigerator for facility stock use. The DON stated multi-dose vials (used more than once) usually expire 28 days after opening the vials and should be discarded beyond that date to prevent accidental use. The DON stated both Aplisol vials were considered expired and needed to be removed from the medication room and be discarded to prevent accidental use. The DON stated using Aplisol vials beyond the expiration date in error may potentially provide inaccurate results for tuberculosis (a contagious bacterial disease that's usually spread through the air when someone with tuberculosis coughs, sneezes, or spits) leading to inaccurate treatment for residents. (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 procedures (P&P) titled, Administering Medications, last reviewed 1/22/2025, the P&P indicated Medications are administered in a safe and timely manner, and as prescribed. 11. The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container. During a review of the facility's P&P titled, Storage of Medications, last reviewed 1/22/2025, the P&P indicated: The facility stores all drugs and biologicals in a safe, secure and orderly manner. 1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. 4. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. During a review of the facility's P&P titled, Medication Labeling and storage, last reviewed 1/22/2025, the P&P indicated: The facility stores all medications and biologicals in locked compartments under proper temperature, light and humidity controls. 2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 5. Multi-dose vials that have been opened or accessed (e.g. needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47441 Based on observation, interview, and record review, the facility failed to follow the menu and did not meet nutritional needs of: a. Twenty seven (27) of 27 residents on puree diet (diet consisting of food with soft pudding-like consistency) and 15 of 15 residents on soft mechanical diet (diet consisting of chopped and soft foods), received less portion for pureed rice and pureed corn as staff did not level off number eight (#8, 1/2 cup) scoop. b. Seven (7) of 7 residents on puree diet and ten (10) of 10 resident on regular texture (no restriction) got mashed potatoes with their tacos in substitution for rice. c. 1 of 1 sampled resident had no alternate menu posted in Station 3 and the room. These failures had the potential to result in decreased food and nutrient intake resulting to unintended (not planned) weight loss. Findings: a. During a review of the facility's menu spreadsheet (a sheet containing kind and amount of food each diet would receive) titled Diet Guide Sheet, dated 1/28/2025, the spreadsheet indicated residents on dysphagia puree diet would include the following foods in the tray: - Pureed chicken fajita 1/2 cup (c, a household measurement) - Pureed cream style corn 1/2 c - Pureed steamed rice 1/2 c - Pureed sliced pears 1/2 c During a review of the facility's menu spreadsheet (a sheet containing kind and amount of food each diet would receive) titled, Diet Guide Sheet, dated 1/28/2025, the spreadsheet indicated residents on dysphagia soft mechanical diet would include the following foods in the tray: - Pureed chicken fajita 1/2 cup (c, a household measurement) - Pureed cream style corn 1/2 c - Pureed steamed rice 1/2 c - Sliced pears 1/2 c (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 1/28/2025 at 12:03 p.m. of the trayline (an area where foods were assembled from the steamtable to the trays), observed cook not leveling off #8 scoop for pureed rice and pureed corn for soft mechanical and puree diets. During an observation on 1/28/2025 at 12:45 p.m. of the trayline, observed cook not leveling off #8 scoop for pureed rice and pureed corn for soft mechanical and puree diets giving less portions. During an observation on 1/28/2025 at 12:53 p.m. of the trayline, observed trayline was running out of soft mechanical chicken fajita and cook was not leveling the #8 scoop full giving less portions. During an interview on 1/28/2025 at 1:41 p.m. with the Dietary Supervisor (DS), the DS stated the spreadsheet indicated portion sizes of food and the right portion size was for staff to fill up the scoop and level it off. The DS stated if staff was not filing the #8 scoop and leveling it off, they were giving the residents less portions. The DS stated if residents received less portions, then the residents would not get the right amount of nutrition causing long term weight loss as a potential outcome. During an interview on 1/29/2025 at 3:20 p.m., with the Registered Dietitian (RD), the RD stated a correct portion size is filling up the scoop and leveling it off. The RD stated if the scoop was not filled and leveled off, there would be less portion size and less calories for the meal provided affecting resident's caloric intake. The RD stated weight loss, delay in wound healing as a long tern effect would be the potential outcome. During a review of the facility's recipe titled, Tortilla, Flour (6 inches)- 1 each, undated, the recipe indicated portion size of puree corn was 1/2 c. During a review of the facility's policy and procedure (P&P) titled Menus, dated 1/22/2025, the P&P indicated, Menus will be planned to meet the nutritional needs of the residents/patients in accordance with the established national guidelines. Menus will be developed to meet the criteria through the use of an approved menu planning guide. Facility unable to provide specific policy for portion sizes when requested. b. During a review of Resident 91's Admission Record, the Admission Record indicated the facility initially admitted Resident 91 on 12/24/2021 and readmitted on [DATE] with diagnoses including type 2 diabetes mellitus (DM 2, a disorder characterized by difficulty of blood sugar control and would healing), chronic kidney disease stage 3 (a condition in which the kidneys are damaged and cannot filter blood as well as they should), and essential hypertension (an abnormally high blood pressure that was not a result of a medical condition). During a review of Resident 91's Minimum Data Set (MDS- a resident assessment tool), dated 11/12/2024, the MDS indicated Resident 91 usually made self understood and understand others. The MDS further indicated Resident 91 required set up and clean up assistance with eating while a resident of the facility and within the last seven days. During a review of Resident 91's Order Summary Report, dated 4/23/2024, the Order Summary Report indicated a physician's order for consistent carbohydrate diet (a diet containing the same amount of carbohydrates per meal for blood sugar management), regular texture (no restriction) and no salt on tray. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/28/2025 at 10:20 a.m. with Resident 91, Resident 91 stated the food sucks, and would not feed this food to a dog. Resident 91 stated having already spoken to the kitchen staff (not identified) about the food quality, but nothing was changed. During a review of the facility's menu spreadsheet titled, Diet Guide Sheet, dated 1/28/2025, the spreadsheet indicated residents on regular diet (no restrictions) would include the following foods in the tray: - Chicken fajita with flour tortilla two (2) each - Chuckwagon corn 1/2 c - Steamed rice 1/2 c - Sliced pears 1/2 c During an observation on 1/28/2025 at 12:53 p.m. of the food in trayline, observed puree rice and regular rice ran out and was substituted with mashed potatoes. During an observation on 1/28/2025 at 1:15 p.m., seven (7) puree trays got mashed potato instead of puree rice while the diet ticket indicated puree rice to be served to the resident. Observed ten (10) regular texture diet trays received mashed potatoes instead of steamed rice. During an interview on 1/28/2024 at 1:31 p.m. with the DS and District Manager (DM), the DM stated the cook did not make enough rice, but the uncooked rice is available. DM stated they substituted rice with mashed potatoes, and it was a weird combination with tacos. DM stated resident would be discontent and would complain as a potential outcome. The DS stated residents would not eat causing weight loss as a potential outcome. During an interview on 1/29/2025 at 3:23 p.m. with the RD, the RD stated rice, and mashed potato has similar carbohydrate content as a substitute, however, when looking at overall menu compatibility, tacos and mashed potatoes combination in a meal would not be ideal, and it could dissatisfy residents as they were expecting certain food (steamed rice) but got other food items. The RD stated residents would not eat the food as a potential outcome. During a review of the facility's P&P titled, Menus, dated 1/22/2025, the P&P indicated, (6) Menus will be served as written, unless a substitution is provided in response to preference, unavailability of an item, or a special meal. During a review of the facility's P&P titled, Food: Quality and Palatability, dated 1/22/2025, the P&P indicated, (1) The Dining Services Director and Cook(s) are responsible for food preparation. Menu items are prepared according to menus, production guidelines, and standardized recipes. (4) The cook(s) prepare food in accordance with the recipes, and season for region and/or ethnic preferences, as appropriate. During a review of the facility's P&P titled, Standardized Recipes, dated 1/22/2025, the P&P indicated, (2) Standardized Recipes will be adjusted to the number of portions required for a meal. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. During a review of Resident 128's Admission Record, the Admission Record indicated the facility initially admitted Resident 128 on 12/28/2023 and readmitted on [DATE] with diagnoses including essential hypertension, pleural effusion (a buildup of fluid between the lungs and chest cavity), and hyperlipidemia (high fat in the blood). During a review of Resident 128's MDS, dated [DATE], the MDS indicated Resident 128 usually made self understood and understand others. The MDS further indicated Resident 128 required supervision and touching assistance (helper provides verbal cues and touch as resident completes the activity) with eating while a resident of the facility and within the last seven days. During a review of Resident 128's Order Summary Report, dated 12/16/2024, the Order Summary Report indicated a physician's order for regular diet (no restriction). During an interview on 1/28/2025 at 11:00 a.m. with Resident 128, Resident 128 stated there were not much food choices and he wanted chicken and fish, but he was not getting his request. Resident 128 stated alternate menu was not available, and he did not know where to find it. During an interview on 1/28/2025 at 11:10 a.m., with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated alternate menu was suppose to be posted by the Station 3 menu board. CNA 2 stated the menu board did not have menu posted that was readable and the alternate menu was not posted on the board. During an interview on 1/28/2025 at 11:12 a.m. with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated the menus were not posted on the three (3) slots intended for menus instead they are in the bottom of the board that were not readable as they were too small and sometimes blocked by the medication cart. LVN 2 stated it was important to post the menus and alternate menus so residents could be reminded of the food served that day and could ask for alternate menu if they changed their minds and if they did not like the food they received. During an interview on 1/30/2025 at 4:30 p.m. with LVN 2, LVN 2 stated there was no visible copy of the weekly menu on the side of Resident 128's room and there was no alternate menu posted. LVN 2 stated it was important that both menus were posted in the resident's room. During a review of the facility's P&P titled, Menus, dated 1/22/2025, the P&P indicated, (8) Menus will be posted in the Dinning Services department, dining rooms, and resident/patient care areas.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47441 Based on observation, interview, and record review, the facility failed to prepare food by methods that conserved appetizing temperature when sliced pears were dished out at 11:45 a.m. with temperature of 68 degrees Fahrenheit (F, a degree of temperature) and the coleslaw was left out in trayline from 12:00 to 12:25 p.m. with a temperature of 75 F. This failure had a potential to result in 149 of 155, including Resident 91, facility residents at risk of unplanned weight loss, a consequence of poor food intake, getting food from the kitchen. Findings: a. During a review of Resident 91's Admission Record, the Admission Record indicated the facility initially admitted Resident 91 on 12/24/2021 and readmitted on [DATE] with diagnoses including type 2 diabetes mellitus (DM 2, a disorder characterized by difficulty of blood sugar control and would healing), chronic kidney disease stage 3 (a condition in which the kidneys are damaged and cannot filter blood as well as they should), and essential hypertension (an abnormally high blood pressure that was not a result of a medical condition). During a review of Resident 91's Minimum Data Set (MDS- a resident assessment tool), dated 11/12/2024, the MDS indicated Resident 91 usually made self understood and understand others. The MDS further indicated Resident 91 required set up and clean up assistance with eating while a resident of the facility and within the last seven days. During a review of Resident 91's Order Summary Report, dated 4/23/2024, the Order Summary Report indicated a physician's order for consistent carbohydrate diet (a diet containing the same amount of carbohydrates per meal for blood sugar management), regular texture (no restriction) and no salt on tray. During an interview on 1/28/2025 at 10:20 a.m. with Resident 91, Resident 91 stated the hot food was cold and the cold food was hot when served. Resident 91 sated the spaghetti and eggs the kitchen served was cold. During a review of the facility's menu spreadsheet titled, Diet Guide Sheet, dated 1/28/2025, the spreadsheet indicated residents on regular diet (no restrictions) would include the following foods in the tray: - Chicken fajita with flour tortilla two (2) each - Chuckwagon corn 1/2 cup (c, a household measurement) - Steamed rice 1/2 c - Sliced pears 1/2 c (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 1/28/2025 at 11:45 a.m., of the trayline (an area where foods are assembled from the steamtable to the resident's plate), staff started placing the sliced pears on the trays in all the carts. During an observation on 1/28/2025 at 12:00 p.m., of the trayline, a container of coleslaw was out by the steamtable without any ice that would make the coleslaw cold. During an observation on 1/28/2025 at 12:27 p.m. of the trayline, the coleslaw has been sitting on the steamtable top. During a concurrent observation and interview on 1/28/2025 at 12:37 p.m. of the coleslaw with the [NAME] 1 and the District Manager (DM), observed the coleslaw temperature was at 75 F. [NAME] 1 stated she put the coleslaw out at around 12:00 p.m. DM stated the coleslaw had to be in an ice bath to keep its temperature cold. During a concurrent test tray (a process of tasting, temping, and evaluating the quality of food) observation and interview with the DM, observed the following temperature temped by the DM for foods: - Chicken fajita 111 F. - Chuckwagon corn 105 F. - Steamed riced 103 F. - Pears 68 F. - Puree chicken fajita 100 F. - Puree tortilla 111 F. - Puree rice 107 F. - Puree pears 65 F. The DM stated the trayline lunch service lasted longer today and the food temperatures were not supposed to be where it was. The DM stated desserts should be about 30 F. The DM stated it was not a good practice for staff to put the dessert ahead of time. The DM stated although the food could be out for two (2) hours for food safety, when residents received food that were not hot or cold, they ended up being dissatisfied. The DM stated resident would not eat the food and would lose weight as a potential outcome. During a review of the facility's policy and procedure (P&P) titled, Food: Quality and Palatability, dated 1/22/2025, the P&P indicated, Food will be prepared by methods that conserve nutrient value, flavor and appearance. Food will be palatable, attractive, and serve at a safe and appetizing temperature. Definitions: Proper (safe and appetizing) temperature: Food should be at the appropriate temperature as determined by the type of food to ensure resident's satisfaction and minimizes the risk for scalding and burns. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Food: Preparation, dated 1/22/2025, the P&P indicated, (13) All foods will be held appropriate temperatures, greater than 135 F (or as state regulation requires) for hot holding, and less than 41 F for cold food holding.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 47441 Based on observation, interview, and record review, the facility failed to prepare foods in a form designed to meet individual needs when puree tortilla was too sticky and did not pass the spoon tilt test (a test used to determine the stickiness of the food and the ability of the food to hold together) and puree corn did not hold its shape for residents on puree diet (foods that are smooth with pudding like consistency)/International Dysphagia Diet Initiative ([IDDSI] a framework for categorizing food textures and drink thickness) level four (4). These failures had the potential to result in difficulty in swallowing, chewing, decreased in food intake and nutrient intake to 27 of 27 residents on puree diet, resulting to unintended weight loss and choking (when food gets stuck in your airway, blocking the flow of air to your lungs). Findings: During a review of the facility's menu spreadsheet (a sheet containing kind and amount of food each diet would receive) titled, Diet Guide Sheet, dated 1/28/2025, the spreadsheet indicated residents on dysphagia puree diet would include the following foods in the tray: - Pureed chicken fajita 1/2 cup (c, a household measurement) - Pureed cream style corn 1/2 c - Pureed steamed rice 1/2 c - Pureed sliced pears 1/2 c During an observation on 1/28/2025 at 12:11 p.m. of the trayline (an area where foods were assembled from the steamtable to resident's plate), observed puree corn was watery and did not hold its shape when plated on the plate. During a concurrent test tray (a process of tasting, temping, and evaluating the quality of food) on 1/28/2025 at 1:34 p.m. of puree diet with the District Manager (DM) and the Dietary Supervisor (DS), the DM stated the corn did not hold its shape on the plate and the visual presentation could be affected and would not be appetizing to the residents. The DM stated the puree tortilla did not fall off the spoon-tilt test and it was too sticky. The DM stated the staff did not add sufficient liquid for the puree tortilla to be a little softer. The DS stated residents would not eat the puree food causing weight loss if the foods were not appetizing to them. The DM stated residents could choke on puree food if it was too sticky as a potential outcome. During a review of the facility's policy and procedure (P&P) titled, Menus, dated 1/22/2025, the P&P stated, Menus will be planned in advance to meet the nutritional needs of the residents/patients in accordance to established national guidelines. Menus will be developed to meet the criteria through the use of the approved menu planning guide. (3) Menu cycles will include standardized recipes. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Standardized Recipes, dated 1/22/2025, the P&P indicated, Standardized recipes shall be developed and used in the preparation of foods. During a review of the facility's recipe titled, Tortilla Flour (6 inches)- 1 each, undated, the recipe indicated, (1) For pureed: measure out desired # of servings into food processor. Blend until smooth. Add liquid if product needs thinning. Add commercial thickener if product needs thickening. During a review of the facility's recipe titled, Corn, Creamed Style (can) 1/2 cup undated, the recipe indicated, (1) For pureed: measure out desired # of servings into food processor. Blend until smooth. Add liquid if product needs thinning. Add commercial thickener if product needs thickening. During a review of the facility's P&P titled, Diet Manual, dated 1/22/2024, the P&P indicated, An approved Diet Manual will be used for menu planning for regular and therapeutic diet plans. (4) The Dinning Services Director and Registered Dietitian/Nutritionist (RDN), or other clinically qualified nutrition professional will ensure that the Diet Manual serves as a guide for ordering diets, and that the menus served will be consistent with the Diet Manual. During a review of the facility's diet and nutrition care manual titled, Dysphagia Puree (Level 1) Diet, dated 1/22/2025, the document indicated, This diet is used only for people who have severe chewing and/or swallowing problems. All foods are pureed to stimulate a soft food bolus, eliminating the whole chewing phase. Thoroughly evaluate individuals before placing on puree diet, and periodically, re-evaluate for ability to advance to the next level of dysphagia diet. All foods must be the consistency of moist, mashed potatoes or pudding. During a review of the IDDSI guideline website titled IDDSI dated 7/2019, the IDSSI website indicated, Level 4 Pureed is usually eaten with spoon, falls off spoon in a single spoonful when tilted and continues to hold shape on the plate, no lumps, not sticky, and liquid must not separate from solid. Food testing method: Spoon tilt test and Fork drip test. (IDDSI, July 2019, The IDDSI Framework section).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47441 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: 1. Kitchen equipment and kitchen areas were not cleaned and sanitized. a. Refrigerator and Freezer floors had dirt build up. b. Vents had dust buildup 2. Preparation [NAME] 1 washed the towel cloth in the preparation sink area while the chicken was thawing on the other sink causing water splatters to go the chicken. 3. Three (3) of four (4) light bulbs in the dry storeroom area were not covered 4. Two (2) dented cans were found with non-dented cans. 5. Twenty one of 21 resident's trays were cracked and chipped. 6. Pots and pans stacked wet. 7. Staff was wearing a bracelet during food preparation. 8. Expired food items of three (3) residents in the refrigerator 9. Residents' freezer temperature was not monitored; there was no thermometer and ice cream stored in it was not rock-solid. These failures had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 149 of 155 medically compromised residents who received food and ice from the kitchen. Findings: 1.a. During an observation on [DATE] at 8:34 a.m., of the walk-in refrigerator, observed dirt debris and dust buildup on the floor. During an observation on [DATE] at 8:35 a.m., observed dirt buildup on the floor in the walk-in freezer. (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 observation and interview on [DATE] at 8:54 a.m., with the District Manager (DM), the DM stated there was dirt buildup in the walk-in freezer and walk in refrigerator floors. The DM stated the last time it was cleaned was last Thursday and it was important to maintain the cleanliness to prevent cross-contamination as they have food in the dirty area. The DM stated the staff only cleaned what they see and what they do not see and needed to deep clean. During a review of the facility's policy and procedure (P&P) titled, Refrigerators and Freezer, dated [DATE], the P&P indicated, This facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation and will observe food expiration guidelines. (10) Refrigerators and freezers will be kept clean, free of debris, and mopped with sanitizing solution on a scheduled basis and more often as necessary. b. During an observation on [DATE] at 11:29 a.m., of the kitchen vents, observed four (4) of 4 vents had dust buildup. During a concurrent observation and interview on [DATE] at 12:12 p.m. of the kitchen vents with the Dietary Supervisor (DS) and the DM, the DS stated the maintenance staff clean the vents, but it had dust buildup. The DS stated he was not sure as to when the last time the vent was cleaned. The DM stated it was not okay as dust could go everywhere including food and could cause cross-contamination. During a review of the facility's P&P titled, Environment, dated [DATE], the P&P indicated, All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition. (1) The Dinning Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation. During a review of Food Code 2022, dated [DATE], the Food Code 2022 indicated, ,d+[DATE].11 (A) Equipment Food Contact Surfaces and utensils shall be cleaned: (1) Except as specified in (B) of this section, before use with a different type of raw animal food such as beef, fish, lamb, pork or poultry; (2) Each time there is a change from working with raw foods to working with ready-to-eat food; (3) Between uses with raw fruits and vegetables and with time/temperature control for safety food. (4) Before using or storing a food temperature measuring device, and (5) At the time during the operation when contamination may have occurred. During a review of Food Code 2022, dated [DATE], the Food Code 2022 indicated,,d+[DATE].13 Nonfood-Contact Surfaces. Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. During a review of Food Code 2022, dated [DATE], the Food Code 2022 indicated, ,d+[DATE].12 Cooking and Baking Equipment. (A) The food contact surfaces of cooking and baking equipment shall be cleaned at least every 24 hours. This section does not apply to hot oil cooking and filtering equipment if it is cleaned as specified subparagraph ,d+[DATE].11 (D)(6). 2. During an initial kitchen tour observation on [DATE] at 8:35 a.m. in the two-compartment sink area, observed staff washing white cloth in the first compartment while thawing raw chicken on the second compartment, causing the water from the first compartment cross-over the pan of the thawing chicken in the second compartment. (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 observation and interview on [DATE] at 9:06 a.m., of the two-compartment preparation sink with the DM, the DM stated there was raw chicken thawing on a pan with cold water on. The DM stated the first sink is used for washing vegetables and the second sink is for thawing. The DM stated they could not wash a cloth in the sink because it could splatter water on the chicken being thawed and it would be cross-contamination. During a review of the facility's P&P titled, Food Preparation, dated [DATE], the P&P indicated, (2) Dining Services staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological and chemical contamination. During a review of Food Code 2022, dated [DATE], the Food Code 2022 indicated, ,d+[DATE].11 Miscellaneous Sources of Contamination. Food shall be protected from contamination that may result from a factor or source not specified under Subparts [DATE]-306. 3. During a concurrent observation and interview on [DATE] at 9:19 a.m., in the storage room [ROOM NUMBER] with the DM, observed three (3) of four (4) light bulbs were not covered. The DM stated it was important to cover the light bulb because of safety and prevention of physical contamination of food. During a review of the facility's P&P titled, Environment, dated [DATE], the P&P indicated, All food preparation areas, food service areas will be maintained in a clean and sanitary condition. During a review of Food Code 2022, dated [DATE], the Food Code indicated, ,d+[DATE].11 Light Bulbs, Protective Shielding. (A) Except as specified in (B) of this section, light bulbs shall be shielded, coated, or otherwise shatter-resistant in areas where there is exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; or unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES. 4. During a concurrent observation and interview on [DATE] at 9:19 a.m., in the storage room [ROOM NUMBER] with the DM, the DM stated there were two dented cans not placed in the dented can area near the emergency supply. The DM stated it was important to separate dented cans from non-dented cans to avoid using it for residents as dented cans can release chemical and metal could go to the food for cross-contamination. During a review of the facility's P&P titled, Receiving, dated [DATE], the P&P indicated (4) All canned foods will be appropriately inspected for dents, rust or bulges. Damaged cans will be segregated and clearly identified for return to vendor for disposal, as appropriate. During a review of Food Code 2022, dated [DATE], the Food Code 2022 indicated, ,d+[DATE].11 Safe Unadulterated, and Honestly Presented. Food shall be safe, unadulterated, and, as specified under , d+[DATE].12, honestly presented. ,d+[DATE].11 Compliance with Food Law. A primary line of defense ensuring that food meets the requirements of S,d+[DATE].11 is to obtain food from approved sources, the implications of which are discussed below. However, it is also critical to monitor food products to ensure that, after harvesting, processing, they do not fail victim to conditions that endanger their safety, make them adulterated, or compromise their honest presentation. The regulatory community, industry, and consumers should exercise vigilance in controlling the conditions to which foods are subjected and be alert to signs of abuse. FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted, and pitted or dented cans may also present a serious potential hazard. 5. During an observation on [DATE] at 11:37 a.m. on the trayline (area where food is assembled from the steamtable to the resident's plate), observed 21 of 21 resident's tray had cracks and chips. During a concurrent observation and interview on [DATE] at 1:45 p.m., of the resident's trays with the Dietary Supervisor (DS) and the DM, the DS stated the trays had cracks and they have requested for it to get replaced however, the DS did not remember as to when the request was made. The DM stated the resident's tray metal was coming out and residents could cut themselves and could be a dignity issue. The DM stated there could be a possible growth of bacteria on the resident's tray because it was not a smooth surface. The DM stated the bacteria from the trays could contaminate the food. During a review of the facility's P&P titled, Equipment, dated [DATE], the P&P indicated, All foodservice equipment will be clean, sanitary, and in proper working condition. During a review of Food Code 2022, dated [DATE], the Food Code 2022 indicated, ,d+[DATE].11 Food-Contact Surfaces. (A) Multiuse Food-contact surfaces shall be (1) Smooth (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections. (3) Free of sharp internal angles, corners, and crevices, (4) Finished to have smooth welds and joints. 6. During an observation on [DATE] at 11:41 a.m., of the storage rack by the dish room, observed the pans were stacked wet. During an interview on [DATE] at 1:48 p.m. of the storage rack by the dishroom with the DS, the DS stated staff air dry the pots and pans at the end of dishmachine area before bringing it to the storage racks. The DS stated the pots and pans were stacked wet, and it was not okay as it could cause moist for bacterial growth. During a review of the facility's P&P titled, Manual Warewashing, dated [DATE], the P&P indicated, (3) All service ware and cookware will be air dried prior to storage. During a review of Food Code 2022, dated [DATE], the Food Code 2022 indicated, ,d+[DATE].11 Equipment and Utensils, air-drying required. After cleaning and sanitizing equipment and utensils: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface sanitizing solutions), before contact with food and; (B) May not be cloth dried except that utensils that have been air-dried may be polished with cloths that are maintained clean and dry. 7. During an observation on [DATE] at 11:32 a.m. of the cooking process, observed [NAME] 1 wearing a bracelet while cooking. During a concurrent observation and interview on [DATE] at 12:01 p.m., of the trayline with the DS, the DS stated [NAME] 1 was wearing bracelet and it was not okay as she could drop it on the food and it is a hazard in the kitchen. The DS stated it could be physical contamination to food so he would ask [NAME] 1 to remove it. (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 review of the facility's P&P titled, Staff Attire, dated [DATE], the P&P indicated, All employees wear approved attire for the performance of their duties. (5) Hand jewelry will be limited to a plain band. Arm jewelry and dangling jewelry is not permitted. A review of Food Code 2022, dated [DATE], the Food Code 2022 indicated ,d+[DATE].11 Prohibition. Except for a plain ring such as wedding band, while preparing food, food employees may not wear jewelry including medical information jewelry on their arms and hands. 8. During a concurrent observation and interview on [DATE] at 3:41 p.m. of the Residents' refrigerator in Station one (1) with Registered Nurse 1 (RN 1), observed three (3) plastic of food dated [DATE]. RN 1 stated they needed to throw expired foods as they only needed to keep the food for 24 hours. RN 1 stated there were three residents' foods that were passed its expiration dates and needed to be thrown away. RN 1 stated residents could have nausea, vomiting and diarrhea upon consumption of expired food. During a review of the facility's P&P titled, Food: Preparation, dated [DATE], the P&P indicated, (17) All refrigerated, ready-to-eat TCS prepared foods that are to be held for more than 24 hours at a room temperature of 41 F or less, will be labeled and dated with a prepared date, (Day 1) or a use by date. During a review of Food Code 2022, dated [DATE], the Food Code 2022 indicated, ,d+[DATE].17 Commercially processed food, open and hold cold, (B) except specified in (E) - (G) of this section, refrigerated, ready-to-eat time/temperature control for food safety food prepared and packed by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacture's use-by- date if the manufacturer determined the use-by date based on food safety. 9. During an observation and interview on [DATE] at 3:47 p.m., of Residents' refrigerator in Station 1 with RN 1, RN 1 stated they were not monitoring the temperature of the freezer as there was no thermometer in it. RN 1 stated the chocolate ice creams stored in the freezer were no rock solid. RN 1 stated it was important to monitor freezer temperature to ensure the product was not spoiled. RN 1 stated the possible outcome from eating expired food were change of condition for residents for nausea, vomiting and diarrhea. During a review of the facility's P&P titled, Refrigerator and Freezer, last reviewed [DATE], the P&P indicated, (1) Acceptable temperature ranges are 35 degrees Fahrenheit (F, a scale of temperature) to 40 F for refrigerators and less than 0 F for freezers. (2) Monthly tracking sheets for all refrigerators and freezers will be posted to record temperatures. During a review of the facility's P&P titled, Food: Safe Handling for Foods from Visitors, dated [DATE], the P&P indicated, (5) Refrigerator/freezers for storage of food brought in by visitors will properly be maintained, and: - Equipped with thermometers (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Have temperature monitored daily for refrigeration less than or equal to 41 F and freezer less than or equal to 0 F. During a review of Food Code 2022, dated [DATE], the Food Code indicated ,d+[DATE].112 Temperature Measuring Devices. (A) In a mechanically refrigerated or hot FOOD storage unit, the sensor of a TEMPERATURE MEASURING DEVICE shall be located to measure the air temperature or a simulated product temperature in the warmest part of a mechanically refrigerated unit and in the coolest part of a hot FOOD storage unit. (B) Except as specified in (C) of this section, cold or hot holding EQUIPMENT used for TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be designed to include and shall be equipped with at least one integral or permanently affixed TEMPERATURE MEASURING DEVICE that is located to allow easy viewing of the device's temperature display.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 47441 Based on observation, interview, and record review, the facility failed to dispose garbage and refuse properly when: a. The trash in the handwashing area was not lined with plastic b. The dumpster's (large trash container designed to be emptied into a truck) surroundings had liquid, food juices spills and trash on the ground and the dumpster was not fully covered. These failures had a potential to result to attracting birds, flies, insects, pest and possibly spread infection to 149 of 156 facility residents. Findings: a. During an observation on 1/28/2025 at 11:30 a.m., in handwashing area, the trash bin was not lined with plastic. During a concurrent observation and interview on 1/29/2025 at 12:44 p.m. with the Dietary Supervisor (DS), the DS stated the trash can by the handwashing machine was not lined and they must put plastic in it as it was not sanitary and for infection control. b. During a concurrent observation and interview on 1/29/2025 at 12:40 p.m. of the dumpster area with the Dietary Supervisor (DS), the DS stated the garbage floor needed to be sprayed and clean as there was liquid spills and dumpster container had sticky dirt. The DS stated the dirt was brown debris and could be anything, food or something else. The DS stated it was not acceptable as it could attract rodents in the facility, and they do not want rodents' infestation (a presence of unusually large number of insect or animal in a place to cause disease). The DS stated the floor has trash too and the cover of the dumpster had a gap not covering the whole dumpster. The DS stated it was not acceptable for the dumpster not to be completely covered as it could attract flies, and it could spread infection. During an interview on 1/29/2025 at 3:55 p.m. with the Maintenance Supervisor (MS), the MS stated the dumpster looked nasty and the sticky dirty could be from the food after seeing a photograph of the dumpster. The MS stated the dumpster was open and needed to always close as it could attract odors and mosquitos. The MS stated the surrounding areas of the dumpster must be clean as it could attract insect causing spread of infection. The MS sated the trash gets picked up everyday but sometimes the vendor does not pick up. The MS stated this was not acceptable as it could spread infection to the residents as a potential outcome. During a review of the facility's policy and procedure (P&P) titled, Environment, dated 1/22/2025, indicated (6) All trash will be contained, covered, leak-proof containers that prevent cross-contamination. (7) All trash will be properly disposed of in external receptables (dumpsters) and the surrounding area will be free of debris. (continued on next page)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Dispose of Garbage and Refuse, dated 1/22/2025, the P&P indicated, All garbage and refused will be collected and disposed in a safe and efficient manner. (1) The Dinning Services Director coordinates with the Director of Maintenance to ensure that the area surrounding the exterior dumpster is maintained in a manner free of rubbish or other debris. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 5-501.113 Covering Receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered: (A) Inside food establishment if the receptacles and units: (1) Contain food residue and are not in continuous use; or (2) After they are filled; and 174 (B) With tight-fitting lids or doors if kept outside the food establishment. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 5-501.116 Cleaning Receptacles. Proper storage and disposal of garbage and refused are necessary to minimize the development of odors, prevent such waste from becoming an attractant and harborage of breeding place for insects and rodents, and prevent the soiling of food preparation and food service areas. Improperly handled garbage creates nuisance conditions, makes housekeeping difficult, and may be possible source of contamination of food, equipment, and utensils. Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. Proper equipment and supplies must be made available to accomplish thorough and proper cleaning of garbage storage areas and receptacles so that unsanitary conditions can be eliminated. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, A review of Food Code 2017, indicated, 5-501.15 Outside receptacles. (A) Receptacles and waste handling units for REFUSE, recyclables, and returnable used with materials containing FOOD residue and used outside the FOOD ESTABLISHMENT shall be designed and constructed to have tight-fitting lids, doors, or covers.

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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** 38552 Based on interview and record review, the facility failed to maintain medical records in accordance with accepted professional standards to two of two sampled residents (Resident 116 and 120) by failing to document if Resident 116's Humulin (a hypoglycemic medication/insulin-a hormone that lowers the level of sugar in the blood) and Resident 120's Lispro (a hypoglycemic medication) doses were administered or not administered. This deficient practice had the potential to result in inaccurate documentation in the medical records regarding the residents' medication administration. Findings: a. During a review of Resident 116's Admission Record, the Admission Record indicated the facility originally admitted the resident on 6/30/2023 with diagnoses including type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN-high blood pressure), and dementia (a progressive state of decline in mental abilities). During a review of Resident 116's History and Physical (H&P), dated 7/3/2023, the (H&P) indicated the resident does not have decision making capacity. During a review of Resident 116's Minimum Data Set (MDS-a resident assessment tool), dated 1/3/2025, the MDS indicated the resident had the ability to make self understood and understand others. The MDS indicated was taking hypoglycemic medications. During a review of Resident 116's physician order, the physician order dated 7/3/2023 indicated Humulin R Injection Solution100 unit/milliliter (ml-a unit of measurement) inject as per sliding scale . subcutaneously (beneath the skin) before meals and at bedtime for DM). During a concurrent interview and record review on 1/31/2025 at 4:46 p.m., with the Director of Nursing (DON), Resident 116's Medication Administration Record (MAR) 1/2025 was reviewed. The MAR indicated missing documentation for Humulin at 6:30 a.m. on 1/8/2025 and 1/11/2025. The DON stated documentation is intended for monitoring if medications are administered as ordered for them to know of the resident's blood sugar levels. The DON stated the staff can do late documentation as soon as they remember. The DON stated the resident would have a potential for hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar) if documentation is not being done. The DON stated when the licensed nurses do not document the medication administration, then it (medication administration) is not done. b. During a review of Resident 120's Admission Record, the Admission Record indicated the facility admitted the resident on 8/22/2024 with diagnoses including type 2 DM, seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), and HTN. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 120's H&P, dated 8/24/2024, the H&P indicated the resident has the capacity to understand and make decisions. During a review of Resident 120's MDS, dated [DATE], the MDS indicated the resident had the ability to make self understood and understand others. The MDS indicated Resident 120 was taking hypoglycemic medications. During a review of Resident 120's physician order dated 12/3/2024, the physician order indicated Insulin Lispro Injection Solution 100 unit/ml inject as per sliding scale . subcutaneously before meals and at bedtime for DM to inject within 15 minutes before meal or with first bite of the meal. During a concurrent interview and record review on 1/31/2025 at 4:46 p.m., with the DON, Resident 120's [DATE]/2025 was reviewed. The MAR indicated missing documentation for insulin lispro on: 1/4/2025 at 11:30 a.m.; 1/8/2025 at 11:30 a.m.; 1/12/2025 at 4:30 p.m. and 9:00 p.m.; 1/15/2025 4:30 p.m. and 9:00 p.m. ; and 1/20/2025 at 11:30 a.m. The DON stated documentation is intended for monitoring if medications are administered as ordered for them to know of the resident's blood sugar levels. The DON stated the staff can do late documentation as soon as they remember. The DON stated the resident would have a potential for hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar) if documentation is not being done. The DON stated when the licensed nurses do not document the medication administration, then it (medication administration) is not done. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, last reviewed and approved on 1/22/2025, the P&P indicated services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care . The following information is to be documented in the resident's medical record: a. objective observations; b. medications administered . 7. Documentation of procedures and treatments will include care-specific details, including a. date and time the procedure/treatment was provided . e. whether the resident refused the procedure/treatment; notification of family, physician or other staff, if indicated; and g. the signature and title of the individual documenting.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44244 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections by failing to: 1. Ensure resident urinals were labeled with a resident identifier for one of two sampled residents (Resident 357) reviewed during the Urinary Tract Infection (UTI- an infection in the bladder/urinary tract) care area. 2. Ensure resident's hand-held nebulizer (HHN - a small machine that turns liquid medicine into a mist that can be easily inhaled) tubing was placed inside the plastic storage after use for one (1) out of two (2) sampled residents (Resident 21) reviewed under the Respiratory care area. This deficient practice had a potential to spread infections and illnesses among residents. Findings: a. During a review of Resident 357's Admission Record, the Admission Record indicated the facility admitted the resident on 3/11/2021 and readmitted the resident on 1/27/2025 with diagnoses that included UTI, benign prostatic hyperplasia (BPH - enlargement of the prostate gland that may result in urinary retention), and depression (persistent feelings of sadness and loss of interest that can interfere with daily living). During a review of Resident 357's History and Physical (H&P), dated 1/27/2025, the H&P indicated the resident was alert to person, place, and time; had fatigue and weakness; and had an unsteady gait. During a review of Resident 357's Care Plan (CP) titled, Resident experiences or is at risk for urinary retention related to BPH, initiated 1/28/2025, indicated to facilitate easy access to the bathroom, urinal, or commode with assistance. During an observation on 1/28/2025 at 9:25 a.m., Resident 357 was observed lying in bed, awake and alert. A used urinal was on the resident's bedside rolling table. Resident 357 stated the staff needed to collect a sample from the urinal. The urinal was not labeled with a resident identifier. During a concurrent observation and interview on 1/28/2025 at 9:30 a.m. with Licensed Vocational Nurse 4 (LVN 4), LVN 4 entered Resident 357's room and stated urinals should be labeled with a resident identifier for infection control reasons. LVN 4 stated the urinal on Resident 357's bedside table was not labeled, but it should have been. LVN 4 stated there were two residents in the room and it was important to label the urinals to ensure the urinal was not used by more than one resident. LVN 4 stated there was a potential for the spread of infection from one resident to another if the same urinal was used for two residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/31/2025 at 8:30 a.m., with the Director of Staff Development (DSD), the DSD stated the facility staff label all urinals with the resident room and bed number to identify the urinal is for one resident. The DSD stated urinals are for single resident use because the urinal may have bacteria on it with the potential for cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect) if used by another resident. During a concurrent interview and record review on 1/31/2025 at 9:30 a.m., with the Director of Nursing (DON), the DON reviewed the facility policy and procedure regarding infection control and personal property. The DON stated urinals are labeled with the resident room and bed number. The DON stated urinals are labeled so they are not interchanged between residents for infection control. The DON stated if a resident had an infection and used a urinal there was a potential it may transfer to another resident if a urinal was shared between the residents. The DON stated a urinal is like personal property and should be labeled. The DON stated the facility policy was not followed when Resident 357's urinal was not labeled. During a review of the facility P&P titled, Infection Prevention and Control Program, last reviewed 1/22/2025, the P&P indicated an infection prevention and control program is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Important facets of infection prevention include: instituting measures to avoid complications or dissemination, and education staff and ensuring that they adhere to proper techniques and procedures. During a review of the facility policy and procedure (P&P) titled, Cleaning and Disinfection of Resident-Care Items and Equipment, last reviewed 1/22/2025, the P&P indicated resident care equipment, including reusable items will be cleaned and disinfected. Reusable single resident-use items are cleaned/disinfected between uses by single resident (e.g. urinals). 43988 b.During a review of Resident 21's Admission Record, the Admission Record indicated the facility admitted the resident on 12/6/2024 with diagnoses including chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), hypertension (HTN - high blood pressure), and generalized muscle weakness. During a review of Resident 21's History and Physical (H&P) dated 12/5/2024, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 21's MDS, dated [DATE], the MDS indicated the resident had an intact cognition (mental action or process of acquiring knowledge and understanding) and required substantial/maximal assistance to total assistance with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 21's Order Summary Report, the Order Summary Report indicated a physician's order dated 1/26/2025: (continued on next page)

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	01/31/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Budesonide Inhalation Suspension (a steroid [a class of drugs that can reduce inflammation in the body] that decreases inflammation in the airways in the lungs which improves airflow and makes breathing easier) 1 MG/2ML one (1) application inhale orally via nebulizer two times a day for shortness of breath for seven days. During a concurrent observation and interview on 1/28/2025 at 9:30 a.m., while inside Resident 21's room with Registered Nurse 2 (RN 2), RN 2 verified Resident 21's HHN set up including the mask, medicine cup, and tubing was just laying on top of the resident's belongings at the bedside table and not placed inside a plastic storage bag. RN 2 stated the licensed nurse should place the HHN set up inside the plastic storage bag at the bedside after use to prevent the set up to be contaminated and cause infection to the resident. RN 2 stated Resident 21's HHN set up should have been placed inside the plastic storage bag to ensure the set up did not get contaminated and placed Resident 2 at risk for acquiring infection due to a contaminated tubing. During an interview on 1/30/2025 at 4:14 p.m. with the Assistant Director of Nursing (ADON), the ADON stated the whole HHN set up are supposed to be placed inside the plastic storage bag after providing HHN treatment to the residents to prevent contamination of the set up. The ADON stated Resident 21's HHN set up should have placed inside the plastic storage bag after HHN treatment to prevent contamination which placed Resident 21 at risk for acquiring infection due to the contaminated tubing. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, last reviewed 1/25/2025, the P&P indicated an infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The P&P further indicated important facets of infection and prevention include: -Instituting measures to avoid complications or dissemination. -Educating staff and ensuring that they adhere to proper techniques and procedures.