STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056115	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Imperial Healthcare Center	11926 LA Mirada Blvd LA Mirada, CA 90638

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858 47092 Based on observation, interview and record review, the facility failed to obtain informed consent prior to administration of psychotropics (medications that affect the mind, emotions, and behavior) for three out of five residents (Resident 3, 48, and 149) by failing to: 1. Ensure an informed consent was obtained and signed by the responsible party (RP) of Resident 3 who could not make medical decisions for treatment with psychotropics. 2. Ensure Resident 48's verification signature was included on the informed consent for treatment with psychotropics. 3. Ensure Resident 149 had an informed consent for treatment with psychotropics. These failures placed Residents 3, 48, and 149 at risk for avoidable harm from unwanted adverse effects (a harmful and undesired effect resulting from a medication or intervention) related to psychotropic medication use and removed the Residents' rights to make decisions about the care and treatments they received in the facility. Findings: 1. A review of Resident 3's Admission Record (Face Sheet), the Admission Record indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that include but not limited to chronic kidney disease (longstanding disease of the kidneys leading to renal failure), type two (2) diabetes mellitus (a condition that results in too much sugar circulating in the blood), and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). The Admission Record indicated Resident 3 was her own Resident Representative. A review of Resident 3's History and Physical Examination (H&P), dated 2/17/2024, the H&P indicated Resident 3 could make her needs known but could not make medical decisions. (continued on next page)

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

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 3's Minimum Data Set ([MDS] a standardized resident assessment and screening tool) dated 2/18/2024, the MDS indicated Resident 3's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 3 had impairments (the state or function being weakened or damaged) on both sides of her upper extremities (upper part of body that includes the shoulder, elbow, wrist, and hand) and lower extremities (lower part of the body that includes the hip, knee, ankle, and foot). The MDS indicated Resident 3 was dependent on staff for toileting, bathing, and dressing. A review of Resident 3's Order Summary Report, dated 5/15/2024, the Order Summary Report indicated to give Mirtazapine (medication to treat depression) 7.5 milligrams (mg, unit of measurement) to Resident 3 for depression as manifested by poor oral intake as evidenced by meal intake less than 50 percent (%) and/or meal refusal. A review of Resident 3's Facility Verification of Informed Consent to Psychotherapeutic Drugs, dated 5/14/24, the Facility Verification of Informed Consent to Psychotherapeutic Drugs indicated, informed consent was provided to the resident or surrogate decision maker for the use of Mirtazapine 7.5 mg, but did not have Resident 3's signature. The Facility Verification of Informed Consent to Psychotherapeutic Drugs indicated, Resident signature on this form is not required. A review of Resident 3's Medication Administration Record (MAR), dated May 2024, the MAR indicated Resident 3 received Mirtazapine 7.5mg on 5/14/2024 and 5/15/2024. During an interview on 5/14/2024 at 3:53 p.m., with the Director of Nursing (DON), the DON stated the resident's physician would document that informed consent was given to either the resident or their representative party (RP). The DON stated the resident, nor the RP had to sign the form. The DON stated only the nurse who confirmed that informed consent was provided would sign the form and then the physician. The DON stated this was the facility's practice for years. During an interview on 5/15/2024 at 12:14 p.m., with Registered Nurse (RN) 1, RN 1 stated the resident's physician would inform the resident and/or their RP about the psychotropic medication they would be given. RN 1 stated the nurse would then confirm that informed consent was given and would sign the Facility Verification of Informed Consent to Psychotherapeutic Drugs. RN 1 stated it was important for the resident and/or their RP to be aware of the medications being administered. During an interview on 5/15/2024 at 3:42 p.m., with the Director of Nursing (DON), the DON stated if Resident 3 could not make medical decisions, as indicated in her H&P, then Resident 3 could not consent to for her own psychotropic medications. The DON stated that Resident 3 was currently taking medications she could not consent for and that has led to inaccurate consent forms in her EHR and possibly the administration of unnecessary medications. 2. A review of Resident 48's Admission Record indicated the facility admitted Resident 48 on 4/30/2024. Resident 48's admitting diagnoses included but were not limited to: chronic obstructive pulmonary disease ([COPD] a group of lung diseases that block airflow and make it difficult to breathe), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). A review of Resident 48's History and Physical (H&P), dated 5/1/2024, indicated Resident 48 had capacity to understand and make decisions. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 48's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 5/4/2024, indicated Resident 48 was cognitively intact. A review of Resident 48's Physician Orders, dated 4/30/2024, indicated Resident 48 was prescribed Sertraline (an antidepressant classified as a psychotropic) 50 milligrams ([mg] a unit of measurement) once daily for depression. A review of Resident 48's Black Box Warning care plan, dated 5/2/2024, indicated Sertraline had a black box warning (now known as a box warning which is intended to bring attention to the major risks associated with high-risk medications) and to monitor Resident 48 for mania (extremely elevated and excitable mood usually associated with bipolar disorder), seizure disorder (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), and suicidal tendencies (the propensity of an individual to experience suicidal thoughts or attempt suicide). Resident 48's Black Box Warning care plan did not indicate informed consent. A review of Resident 48's Facility Verification of Informed Consent to Psychotherapeutic Drugs, dated 4/30/2024, indicated an informed consent was provided regarding the risks and benefits of Sertraline use, but did not have a signature of either Resident 48 or his responsible party. A review of Resident 48's Medication Administration Record, dated 5/2024, indicated Resident 48 received Sertraline 50 mg daily 5/2/2024 through 5/14/2024. During a concurrent observation and interview on 5/15/2024, at 8:35 a.m. with Resident 48, Resident 48 was awake, alert, oriented, and was sitting in his chair. Resident 48 stated he did not recall a physician or anyone else discussing the risks or benefits of Sertraline. During an interview on 5/15/2024, at 8:38 a.m., with Resident 48's wife, Family Member (FM 1), FM 1 stated she was not aware her husband (Resident 48) was on antidepressants (a psychotropic medication used to treat depression), and the facility did not discuss the risks and benefits with her or Resident 48 regarding Sertraline. 3. A review of Resident 149's Admission Record indicated the facility admitted Resident 149 on 5/3/2024. Resident 149's admitting diagnoses included but were not limited to: fracture of the thoracic 5-6 ([T5-T6] spinal bones 5 and 6 out of 12 in the middle of the back) vertebra (spinal bone column), and neuropathy (a nerve problem that causes pain, numbness, tingling, swelling, or muscle weakness in different parts of the body). A review of Resident 149's History and Physical (H&P), dated 5/5/2024, indicated Resident 149 had capacity to understand and make decisions. A review of Resident 149's Physician Orders, dated 5/3/2024, indicated Resident 149 was taking Duloxetine (an antidepressant classified as a psychotropic) 30 mg by mouth once daily for neuropathy. A review of Resident 149's Black Box Warning care plan, dated 5/7/2024, indicated Duloxetine had a black box warning and to monitor Resident 149 closely for suicidal thoughts and behaviors, and hyponatremia (low sodium in the blood). (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 149's Medication Administration Record, dated 5/2024, indicated Resident 149 received Duloxetine 30 mg once daily 5/4/2024 through 5/16/2024. During an interview on 5/15/2024, at 9:48 a.m., with Registered Nurse (RN) 1, RN 1 stated an informed consent is not obtained by the facility for off label use (the practice of prescribing a drug for a different purpose than what was approved by the regulatory agency) of psychotropic medications, and Resident 149 did not have an informed consent in the chart because it was not needed. During an interview on 5/15/2024, at 2:56 p.m., with the Director of Nursing (DON), the DON stated they did not have an informed consent for Resident 149 because per their policy for informed consent was not required for off-label use, and was not prescribed as a chemical restraint (a form of medical restraint which a drug is used to restrict the freedom of movement of a patient or in some cases to sedate the patient). The DON stated the physician would be the one to explain the risks and benefits to the resident or responsible party for informed consent, and a licensed nurse would verify with the resident or responsible party that the risks and benefits were explained to them. The DON stated but the facility did not require a signature from the resident or responsible party on their Verification of Informed Consent form because that was how they have always done it. During an interview on 5/16/2024, at 11:32 a.m. with the DON, the DON stated an informed consent verification form did not require a signature by the resident or responsible party. A review of the facility policy and procedure (P&P) titled Verification of Informed Consent for Psychotherapeutic Medications and Physical Restraints, dated 8/2014, indicated the facility is responsible to assure that consent was obtained by the physician. The P&P further indicated the facility will not be responsible for obtaining a signature from the resident, responsible party, or public guardian. A review of the facility policy and procedure (P&P) titled Behavioral Assessment, Management, Psychoactive Medications and Monitoring, dated 12/2020, indicated the facility will comply with regulatory requirements related to the use of medications to manage behavioral changes, and off label psychotherapeutic medications do not require an informed consent. A review of the California Department of Public Health All Facilities Letter (AFL), dated 2/28/2024, indicated facilities must obtain a resident's written informed consent for treatment using psychotherapeutic drugs, and consent renewal every six months, which must be signed by the resident or resident's representative.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on observation, interview, and record review, the facility failed to ensure dignity was maintained for one of three sampled residents (Resident 86) when the privacy curtain was left open while Resident 86 was left exposed (without any clothes on) in only their diaper. This failure had the potential to result in Resident 86 having a decreased feelings of self-worth and self-confidence and the potential for feelings of humiliation. Findings: A review of Resident 86's Admission Record (Face Sheet), the Admission Record indicated Resident 86 was admitted to the facility on [DATE] with diagnoses that include but not limited to anoxic (a total depletion in the level of oxygen) brain damage, major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and benign prostatic hyperplasia ([BPH] age-associated prostate gland enlargement that can cause urination difficulty). A review of Resident 86's Minimum Data Set (MDS, a standardized resident assessment care screening tool), dated 3/18/2024, the MDS indicated Resident 86 was able to understand and be understood by others. The MDS indicated Resident 86's cognition (process of thinking) was intact. The MDS indicated Resident 86 required supervision when dressing. The MDS indicated Resident 86 required moderate assistance (requires assistance from helper, who provides less than half the effort) with oral and personal hygiene. The MDS indicated Resident 86 required maximal assistance (requires assistance from helper, who provides more than half the effort) with toileting and bathing. The MDS indicated Resident 86 was frequently incontinent (lacking control) of his stool. During an observation on 5/15/2024 at 10:23 a.m. in Resident 86's room with Certified Nursing Assistant (CNA 4), CNA 4 opened the privacy curtain (piece of material that is hung to provide privacy) in Resident 86 room and Resident 86, who was uncovered, was lying on his bed with only a diaper on. During an interview on 5/15/2024 at 10:30 a.m., with CNA 4, CNA 4 stated Resident 86 would let her know if he needed his diaper changed. CNA 4 stated Resident 86 does not like to wear a gown or other clothing items when he was in bed but would like to be covered with a blanket. CNA 4 whenever a resident was exposed in a diaper, the privacy curtain should be closed. CNA 4 stated ensuring the residents were covered when exposed in a diaper was to protect the resident's dignity. During an interview on 5/15/2024 at 10:38 a.m., with Resident 86, Resident 86 stated when he was exposed in his diaper, he wanted the curtain, or the door closed so he could have privacy. Resident 86 stated he did not like wearing the gown or other clothes in the bed but wanted the blanket covering him to provide privacy. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/15/2024 at 1:08 p.m. with the Registered Nurse (RN 2), RN 2 stated a resident in only a diaper would be considered as exposed. RN 2 stated when a resident has only a diaper on and a staff member assisting them, the privacy curtain should be closed. RN 2 stated the curtain should be kept closed until Resident 86 was covered with either a gown, clothing, or a blanket. RN 2 stated the staff were responsible for treating all residents with respect and to maintain their dignity. During an interview on 5/16/2024 at 2:09 p.m., with the Director of Nursing (DON), the DON stated to treat all residents with dignity and respect. The DON stated it was important for the staff to maintain the residents' privacy and whenever care was provided to a resident, the curtain should be pulled closed to ensure privacy. The DON stated when Resident 86 was exposed, the curtain should have been closed and should have only be opened once the resident was dressed or covered. The DON stated it was unacceptable to leave Resident 86 lying in bed exposed in a diaper with the curtain open. The DON stated there was a possibility that Resident 86 could have felt embarrassed that he was exposed in his diaper to the public. A review of the facility's policy and procedure (P&P) titled, Dignity, undated, the P&P indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem; residents are treated with dignity and respect at all times . staff should promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care during treatment procedures.

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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** 47858 45382 Based on observation, interview, and record review, the facility failed to develop and/or implement an individualized person-centered plan of care with measurable objectives, timeframe, and interventions to meet the residents' needs for two of eight sampled residents (Residents 74 and 78) by failing to: a. Ensure Resident 74 was consistently turned and repositioned (during the month of March [2024]) as indicated on a pressure ulcer ([PU]-injury to skin and underlying tissue resulting from prolonged pressure on the skin) care plan to prevent the development of an unstageable (full thickness tissue loss) pressure ulcer. b. Develop and implement a care plan for Resident 78's multiple and consecutive RNA refusals. These deficient practices led to the development of an unstageable pressure ulcer on Resident 74's right medial lower leg and had the potential to negatively affect the delivery of necessary care and services for Residents 74 and 78. Findings: a. A review of Resident 74's Admission Record indicated Resident 74 was admitted to the facility on [DATE] with diagnoses that included a history cerebral infarction (disruption in blood flow in the brain), contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints), pressure ulcer of sacral region (area on the posterior side of the body's pelvis) unstageable and gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food). A review of Resident 74's ([MDS]- a standardized assessment and care planning tool), dated 2/16/2024, indicated Resident 74's cognition (ability to think and reason) was severely impaired. The MDS indicated Resident 74 was completely dependent on staff for all activities of daily living and personal hygiene needs. The MDS indicated Resident 74 had a feeding tube (tube inserted directly in the stomach for nutrition). A review of Resident 74's Situation Background Assessment Recommendation (SBAR) communication form dated 3/28/2024, indicated Resident 74 had four new diabetic ulcers and one right medial lower leg unstageable pressure ulcer, that measured 2.0 centimeters ([cm]- a unit of measurement) by 1.8cm and had an undetermined depth. The SBAR form indicated turning and repositioning Resident 74 every 2 hours and properly offloading resident's wounds would make the condition or symptom better. A review of Resident 74's Skin Impairment Care Plan, dated 3/28/2024, indicated Resident 74 had a diabetic ulcer of the right lateral (side) fourth toe, and the care plan interventions were to change Resident 74's position every two hours. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 74's Wound Care Note dated 3/21/2024 indicated the Wound Nurse Practitioner (WNP) recommended to change positions often to keep pressure off the wound . for Resident 74. A review of Resident 74's Skin Ulcer Weekly Report dated 3/21/2024 indicated the facility's preventative measures were to place Resident 74 on the turning and repositioning program. A review of Resident 74's Turning and Repositioning monitoring log dated 3/1/2024 to 3/28/2024 (date of the discovery of the PU) indicated Resident 74 was turned and repositioned on the following dates and times: -3/2/2024, at 1:40 p.m., no documented repositioning performed until 10:41 p.m. -3/3/2024, at 2:00 p.m., no documented repositioning performed until10:34 p.m. -3/4/2024, at 1:28 p.m., no documented repositioning performed until 3/5/2024 at 5:33am. -3/5/2024, at 5:34 a.m., no documented repositioning performed until 2:31 p.m., and no other documented reposition performed until 3/6/2024, at 4:55 a.m. -3/21/2024, at 9:31 a.m., no documented repositioning performed until 7:51 p.m. -3/28/2024 (date of the discovery of the PU), at 4:57 a.m., no documented repositioning performed until 2:21 p.m. During an interview on 5/15/2024 at 1:08 p.m. with the Licensed Vocational Nurse (LVN 2), LVN 2 stated it was important to turn [the resident] every two hours to relieve pressure and to avoid the development of pressure ulcers. LVN 2 stated if Resident 74 was not repositioned very two hours, then the likelihood of Resident 74 to develop a pressure ulcer would increase. LVN 2 stated a pressure ulcer was considered harm for any resident and stated that the lack of turning may have led to the development of Resident 74's pressure ulcer. During an interview on 5/16/2024 at 8:37 a.m. with the Wound Nurse Practitioner (WNP), the WNP stated that to prevent the development of a pressure ulcer for a resident like Resident 74, it was important to properly turn and reposition Resident 74, every two hours, so that all her bony prominences (areas where bones are close to the surface of the skin) could be offloaded. The WNP stated, An unstageable pressure ulcer could definitely develop within two hours of not being repositioned. During an interview on 5/16/2024 at 10:56 a.m. with CNA 2, CNA 2 stated that the usual process was to turn and reposition residents who were at risk of developing pressure ulcers and document the task in the resident's chart. CNA 2 stated that if Resident 74 was not turned and repositioned consistently, then Resident 74 could form a bad pressure ulcer. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/16/2024 at 12:38 p.m. with RN 1, RN 1 stated the nursing staff were to ensure residents are repositioned and turned every two hours, good perineal care was provided and that all change of conditions were reported to the charge nurse so that care is not delayed. RN 1 also stated a care plan was important so that interventions could be implemented to care for the resident. RN 1 stated if Resident 74 was not repositioned every two hours, then it was possible that the lack of turning and repositioning led to the development Resident 74's unstageable pressure ulcer and that it did not align with Resident 74's current pressure ulcer care plan. During an interview on 5/16/2024 at 3:52 p.m. with the Director of Nursing (DON), the DON stated the facility staff was following Resident 74's pressure ulcer care plan if Resident 74 was not repositioned every two hours. The DON stated that if Resident 74 was not turned every two hours, Resident 74 would be subject to another pressure injury or worsening of Resident 74's pressure ulcers. A review of the facility's Policy and Procedure (P&P) titled, Repositioning dated 5/2013 indicated the following: 1. Repositioning was critical for a resident who is immobile or dependent upon staff 2. Residents who are in bed should be on at least every two-hour repositioning schedule. 3. Residents with a Stage I or above pressure ulcer, every two-hour repositioning schedule is inadequate. b. A review of Resident 78's Admission Record indicated the facility admitted Resident 78 on 10/9/2023 with diagnoses including spinal stenosis (condition that occurs when the spaces in the spine narrow and put pressure on the spinal cord and nerve roots), peripheral autonomic neuropathy (disorder that affects then nerves that control the body's processes without conscious effort), and malignant neoplasms (cancerous tumors) of the bladder and kidney. During a review of Resident 78's Minimum Data Set ([MDS] an assessment and care-screening tool) dated 4/11/2024, the MDS indicated Resident 78 was cognitively (ability to think, understand, learn, and remember) intact. The MDS indicated Resident 78 was independent in eating, hygiene, toileting, bathing, and transfers and required supervision or touching assistance for walking 150 feet. The MDS indicated Resident 78 had no functional limitations in range of motion (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in both arms (shoulder, elbow, wrist, hand) and both legs (hip, knee, ankle, foot). During a review of Resident 78's Physician's Orders dated 10/26/2023, the Physician's Orders indicated for Resident 78 to receive the Restorative Nursing Aide program ([RNA] nursing aide program that helps residents maintain their function and joint mobility) for ambulation (walking) exercises using a single point cane (device used to help with stability when walking), five times a week. During a review of Resident 78's November 2023 RNA Documentation Survey Report, the Survey Report indicated Resident 78 refused RNA services for ambulation exercises on 11/1/2023, 11/2/2023, 11/13/2023, 11/14/2023, 11/15/2023, 11/16/2023, 11/17/2023, 11/20/2023, and 11/21/2023. (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 78's Interdisciplinary Team ([IDT] team of health care professionals that work together with the resident and or resident's representative to prioritize the resident 's needs and goals) Conference Record dated 11/15/2023, the IDT Conference Record indicated the team including discussed plans to discontinue Resident 78's RNA services for ambulation with Resident 78. During a review of Resident 78's Physician's Orders dated 11/21/2023, the Physician's Orders indicated to discontinue RNA services. During a review of Resident 78's care plans, there was no care plan in place that addressed Resident 78's refusals of RNA services. During a concurrent observation and interview on 5/14/2024 at 12:51 p.m., Resident 78 was observed sitting at the edge of the bed eating lunch. Resident 78 stated he received RNA services to assist with walking exercises with a cane when he was discharged from Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function). Resident 78 stated he no longer had RNA services to assist with exercises and walking and did not know why. Resident 78 stated he walked with a cane and used a wheelchair for longer distances such as going outside. During an interview and record review on 5/16/2024 at 10:19 a.m., the Minimum Data Set Coordinator (MDSC) stated the care plan was a comprehensive (inclusive, including everything necessary) individualized plan of care created to address the resident's needs. The MDSC reviewed Resident 78's care plan and RNA Documentation Survey Reports for November 2023 and confirmed Resident 78 refused RNA multiple times and did not have a care plan to address Resident 78's multiple and consecutive RNA refusals. The MDSC stated it was important the facility developed a care plan for multiple RNA refusals to ensure there were goals and interventions in place to ensure the resident maintained his or her current level of function. The MDSC stated if multiple RNA refusals were not care planned, the facility may not be providing the appropriate care and services the residents need to maintain mobility and range of motion (full movement potential of a joint) which could potentially lead to a functional decline. During an interview on 5/16/2024 at 11:43 a.m. with the DON, the DON stated comprehensive care plans were developed for every resident and used as a guide for staff to identify the type of care to provide the residents in the facility. The DON stated if a resident refused RNA services more than three consecutive times, an IDT meeting should be done, the Rehabilitation department should be notified, and a comprehensive care plan should be developed and escalated to ensure the facility had the proper interventions in place to prevent a decline. The DON stated it was important for care plans to be developed, implemented, and accurate to ensure the appropriate care was provided to each individual resident. (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 the facility's Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 12/2016, the P&P indicated a comprehensive, person-centered care plan should include measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. The P&P indicated the care plan should describe the services that are to be furnished to assist the resident attain or maintain that level of physical, mental, and psychosocial well-being that the resident desires or that is possible. The P&P indicated the comprehensive care plan would describe services that would otherwise be provided but were not provided due to the resident's right to refuse treatment. The P&P indicated the resident had the right to refuse to participate in nursing treatment and such refusals would be documented in the resident's clinical record in accordance with established policies.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092 Based on observation, interview and record review, the facility failed to prevent an avoidable pressure ulcer (localized skin and soft tissue injuries that form as a result of prolonged pressure and shear, usually exerted over bony prominences) for one out of three residents (Resident 30). This deficient practice resulted in Resident 3 having a stage II pressure ulcer (an open wound with partial thickness loss where the top layer of the skin has been damaged). A review of Resident 30's Admission Record indicated the facility originally admitted Resident 30 on 3/12/2021 and readmitted on [DATE] with diagnoses of pneumonia (an infection of the lungs), type 2 diabetes mellitus (a metabolic disorder where the pancreas cannot produce enough insulin to digest sugars properly, causing high blood sugar that damages organs over time if not controlled), sepsis (infection of the blood) due to streptococcus pneumoniae (a bacteria often the cause of pneumonia), and asthma (a respiratory condition marked by spasms in the broncho of the lungs, causing difficulty in breathing as a result of an allergic reaction). A review of Resident 30's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 3/1/2024, indicated Resident 30 was moderately cognitively impaired (impaired ability to think and reason), and had required moderate assistance (helper does less than half the effort) for rolling from left to right when turning or repositioning in bed. The MDS indicated Resident 30 was non-ambulatory and required maximal assistance (helper does more than half the effort) for getting out of bed to chair or from lying to sitting in bed. A review of Resident 30's History and Physical (H&P), dated 3/5/2024, the H&P indicated Resident 30 had capacity to understand and make decisions. A review of Resident 30's care plan titled Potential for skin impairment, dated 3/14/2024, indicated Resident 30 was at risk for skin impairment. The care plan interventions indicated for staff to assist resident with turning and repositioning every 2 hours. A review of Resident 30's SNF Wound Care note, dated 5/10/2024, indicated Resident 30 had intact skin from a body assessment. During an interview on 5/13/2024, at 11:43 a.m., with Resident 30, Resident 30 stated on 5/12/2024, Resident 30 had a newly developed bed sore on her lower back per the licensed nurse, but did not have one on 5/11/2024, and did not remember which nurse had told her about it. During an interview on 5/13/2024, at 3:43 p.m., with Certified Nursing Assistant (CNA 1), CNA 1 stated Resident 30 did not have any skin break down or redness 5/12/2024 when she had last worked with Resident 30. CNA 1 stated bed bound (unable to get out of the bed without assistance) residents need to be turned every 2 hours or sooner to prevent skin damage. During an observation on 5/14/2024, at 9:33 a.m., Resident 30 had a stage II pressure ulcer on her sacrum (lower back) which was covered by a dressing with a scant amount of serosanguinous (blood and blood fluid contents) drainage on it. (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 5/14/2024, at 1:59 p.m., with the Treatment Nurse (TXN), the TXN stated to her knowledge Resident 30 did not have any skin break down and nobody had informed her of any changes in Resident 30's skin assessment. The TXN stated Resident 30 should be turned every 2 hours by CNAs to offload (prevent vulnerable areas prone to skin break down from having too much pressure by use of a prop such as a pillow) pressure and prevent skin break down. During an interview on 5/14/2024, at 3:28 p.m., with TXN, TXN stated Resident 30 had developed a stage II pressure ulcer after 5/10/2024 because she had assessed Resident 30 on 5/10/2024 and Resident 30 had no skin break down at that time. During an interview on 5/15/2024, at 9:54 a.m., with Registered Nurse (RN 1), RN 1 stated residents who are bed bound had to be repositioned every 2 hours or more and should be encouraged to get out of bed to offload vulnerable pressure areas to prevent skin breakdown. RN 1 stated any skin break down that was observed by any of the nurses must be reported to the charge nurse and treatment nurse. RN 1 stated there was nothing in Resident 30's medical record indicating a new report of skin break down, and the facility staff did not notify him of the change in Resident 30's skin assessment. During an interview on 5/16/2024, at 11:27 a.m., with the Director of Nursing (DON), the DON stated if staff had observed any skin changes on Resident 30 it should have been reported to the charge nurse and a change of condition (a clinical deviation from a resident baseline health status) note should have been initiated. A review of the facility policy and procedure (P&P) titled Pressure Ulcers/Injuries, dated 7/2017, indicated an avoidable pressure ulcer means that the resident developed a pressure ulcer/injury and that the one or more of the following was not completed: a. Evaluation of the resident's clinical conditions or risk factors. b. Definition of Implementation of interventions that are consistent with resident's needs, resident goals, and professional standards of practice. c. Monitoring or evaluation of the impact of the interventions. d. Revision of the interventions as appropriate.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858 47679 Based on observation, interview, and record review, the facility failed to ensure fall measures were implemented to prevent the occurrence of further falls and injuries for two out of two sampled residents (Resident 64 and Resident 194) who sustained major injuries after a fall within the facility when the facility staff failed to: 1. Ensure bilateral fall mats were in place for Resident 64. 2. Ensure a falling star sticker was placed to the name plates of Resident 64 and Resident 194. These failures had the potential for Resident 64, who had fallen on 4/10/2024, sustained a broken left hip and underwent an open reduction internal fixation ([ORIF]- surgery to repair the hip) of the left hip (because of the fall), to endure another fall. These failures also had the potential for Resident 194, who sustained a traumatic subarachnoid hemorrhage (bleeding in the space between brain and the surrounding membrane) due to a fall within the facility, to sustain further bodily injury from another fall. Findings: a. A review of Resident 64's, Admission Record, indicated Resident 64 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included history of falling, fracture of the neck of the left femur (broken left hip bone), muscle weakness, hemiplegia (muscle weakness affecting one side of the body) and hemiparesis (muscle weakness affecting one side of the body) following cerebral infarction (disruption of blood flow in the brain) affecting the right dominant side, and epilepsy (uncontrollable brain activity that affects the function of the body). A review of Resident 64 's ([MDS]- a standardized assessment and care planning tool), dated 12/21/2023 (before the fall), indicated Resident 64 required supervision when performing toilet transfers, sitting to standing, and partial to moderate assistance (patient performance of 50% of a task and care giver assists with 50%) when walking 10 feet. A review of Resident 64 's MDS, dated [DATE], indicated Resident 64's cognitive skills (mental action or process of acquiring knowledge and understanding) was severely impaired. The MDS indicated Resident 64 required substantial or maximal assistance (patient performance of 25% of a task and care giver assists with 75%) when transferring to the toilet, sitting to standing, and moderate assistance walking 10 feet. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 64's Situation Background Assessment Recommendation (SBAR) note dated 4/10/2024, indicated Resident 64 suffered an unwitnessed fall and Resident was noted on the floor in front of [the] roommate's bed near the door . She was found on floor lying on her left side. Resident ambulated without assistance. Call light was in reach near her wheelchair left side of her bed. The SBAR note indicated Resident 64 complained of 10/10 pain to her left leg and was sent to General Acute Care Center (GACH). A review of Resident 64's At risk for further falls Care Plan, dated 4/19/2024, indicated that Resident 64 was at risk for falls secondary to status post left hip ORIF, hemiplegia, and hemiparesis following cerebral infarction. The facility's interventions, initiated 4/19/2024, were to use an injury prevention device such as floor mats, low bed, concave mattress . and place a falling star sticker to indicate resident in a fall prevention program. A review of Resident 64's Fall Risk Assessment, dated 4/16/2024 (date of readmission), indicated Resident 64 scored a 15 (a score of 10 or more on the fall risk assessment was considered a high risk for falls) and was at high risk for falls. During observations made on 5/13/2024 at 10:05 a.m. and 5/14/2024 at 10:00 a.m., there were no fall mats in place, on either side of Resident 64's bed, and no falling star sticker was placed on Resident 64's name plate. During a concurrent observation and interview on 5/14/2024 at 12:23 p.m. with Certified Nursing Assistant (CNA 3), Resident 64's room was observed without any fall mats in place on the floor on either side of Resident 64's bed, and no falling star sticker was placed on Resident 64's name plate. CNA 3 stated there should have been fall mats on the floor for Resident 64, because she recently had a fall and so that all staff could identify Resident 64 as a high fall risk resident. CNA 3 stated that the fall mats were important to lessen the impact of a fall. During an interview, on 5/14/2024, at 12:39 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated that Resident 64 recently had a fall was at high risk for falls and. LVN 1 stated that if there were no fall mats in place, the impact of a fall would cause greater injury. LVN 1 stated that Resident 64 required floor mats and a falling star sticker. During an interview, on 5/15/2024, at 12:36 p.m., with Registered Nurse (RN 2), RN 2 stated the facility usually placed fall mats on either side of the resident's bed if a resident was identified as high fall risk. RN 2 stated a star sticker was also placed on all name plates of the residents' that were identified as a high fall risk. RN 2 stated that Resident 64 was at high risk for falls and fall mats should have been placed in her room. RN 2 stated that prior to Resident 64's most recent fall (on 4/10/2024), Resident 64 was known to be forgetful, had a tendency to get up on her own and required more monitoring. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/16/2024 at 2:13 p.m. with the Director of Nursing (DON), the DON, stated that the facility usually performed a fall risk assessment and used the assessment to determine which interventions to put into place. The DON stated that a score of 10 or more on the fall risk assessment was considered a high risk for falls. The DON stated that if a resident that is high risk for falls does not have a star sticker, then there was a potential that the resident would not be closely monitored and fall, as result. The DON stated that Resident 64 did not need floor mats in place because the resident had limited mobility due to her recent surgery. The DON confirmed that Resident 64 was readmitted to the facility on [DATE] after her hospitalization for the fall. The DON stated that fall interventions including the Falling Star Program needed to be implemented immediately after a resident had a fall to prevent the possibility of another fall. The DON stated it was not acceptable to implement fall precautions a month after Resident 64 had been readmitted to the facility. A review of Resident 64's Physical Therapy Evaluation and Plan of Treatment dated 4/17/2024 indicated Resident 64 was at risk for falls due to documented physical impairments and associated functional deficits (limitation or impairment of physical abilities/function resulting in evaluation and inclusion in a treatment plan of care). A review of Resident 64's Physical Therapy Treatment Encounter Note, dated 5/7/2024 indicated Resident 64's functional status progressed to minimal assistance for the following tasks: bed mobility, rolling, laying down to sitting and sitting to laying down. The PT treatment encounter note also indicated Resident 64 required moderate assistance when sitting to standing and transferring from the bed. A review of the facility's Policy and Procedure (P&P) titled, Falling Star Program (undated), indicated the falling star stickers were visual identifiers that would assist the facility staff identify those residents that were at risk for falls, and to respond accordingly when the resident demonstrated a behavior that may have been associated with an impending fall. The P&P indicated that a falling star sticker needed to be placed if a resident was identified for the program. The P&P indicated a falling star symbol would be placed by the entry door next to the name of the resident. A review of the facility's P&P titled Falls and Fall Risk Managing dated 3/2020 indicated the facility was to utilize floor mats when indicated to prevent injuries related to falls from bed. A review of the facility's P&P titled Safety and Supervision of Residents dated 7/2017 indicated the facility was to strive to make the environment as free from accident hazards as possible. The P&P indicated that resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The P&P indicated the care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. b. A review of Resident 194's Admission Record (Face Sheet), the Admission Record indicated Resident 193 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that include but not limited to traumatic subarachnoid hemorrhage (bleeding in the space between brain and the surrounding membrane), end stage renal disease (ESRD, a stage where the kidneys can no longer support the body's needs for waste removal and fluid balance), and type two (2) diabetes mellitus (a condition that results in too much sugar circulating in the blood). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 194's MDS, dated [DATE], the MDS indicated Resident 194 was able to understand and be understood by others. The MDS indicated Resident 194's cognition (process of thinking) was intact. The MDS indicated Resident 194 had impairment on both sides of his lower extremities (lower part of the body that included the hip, knee, ankle, and foot). The MDS indicated Resident 194 requires supervision when eating. The MDS indicated Resident 194 required moderate assistance with oral hygiene. The MDS indicated Resident 194 required maximal assistance with toileting, bathing, dressing, and rolling left and right on the bed. A review of Resident 194's History and Physical Examination (H&P), dated 5/13/2024, the H&P indicated Resident 194 had the capacity to understand and make decisions. A review of Resident 194's Fall Risk Assessment, dated 4/26/2024 and 5/10/2024, the Fall Risk Assessment indicated Resident 194 was at a high risk for falls. A review of Resident 194's Care Plan (CP), initiated on 5/11/2024, the CP indicated Resident 194 had a fall on 5/4/2024 that resulted in a subarachnoid hemorrhage. The CP goals indicated Resident 194's injuries would resolve without complication. The CP intervention included to place a falling star sticker to indicate that Resident 194 was in the fall prevention program. During an observation on 5/13/2024 at 12:54 p.m. and on 5/14/2024 at 1:45 p.m., outside of Resident 194's room, there was no star symbol sticker next to Resident 194's name. During an interview on 5/15/2024 at 12:35 p.m. with RN 2, RN 2 stated when a resident falls, the staff should be made aware that they are a fall risk. RN 2 stated to communicate to the staff of the resident's risk for falls, a star symbol sticker is placed next to their name outside the room. RN 2 stated the star symbol next to their name would ensure the staff were aware that the resident required additional monitoring to prevent further falls. RN 2 stated without the star symbol sticker next to Resident 194's name, there was potential for miscommunication within the staff and they would not be aware that Resident 194 was at high risk for falls. During an interview on 5/16/2024 at 2:15 p.m. with the DON, the DON stated a resident was placed on the Falling Star Program based on their Fall Risk Assessment and if the Interdisciplinary Team (IDT, a group of healthcare professionals with various areas of expertise who work together towards the goals of the residents) had determined the resident would benefit from the program. The DON stated to identify if a resident was part of the Falling Star Program was to place a yellow star sticker next to their name by the door. The DON stated the sticker allowed for easy identification of the staff to recognize the residents that were a fall risk. The DON stated when a resident was placed on the Falling Star Program, the staff were aware to watch those residents more closely because they had the potential to fall. The DON stated without a star symbol sticker next to Resident 194's name, there was the potential that Resident 194 would not be monitored closely as frequently as needed and Resident 194 could have another fall incident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure (P&P) titled, Falling Star Program undated, the P&P indicated The falling star is a visual identifier/reminder program for staff to recognize and to be aware of residents determined to be at risk. The P&P indicated identifiers will assist the facility staff as well as family and visitors to identify those residents that are at risk for falls, and to respond accordingly when the resident demonstrates a behavior that may be associated with an impending fall. The P&P indicated if resident is identified for the program, a falling star symbol will be placed on any or all of the locations by the entry door next to the name of the resident.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092 Based on observation, interview and record review, the facility failed to provide respiratory care services according to professional standards for Resident 30 by failing to: 1. Change Resident 30's oxygen tubing and humidifier (a device used to keep oxygen delivery moist to prevent irritation to the airway) within one (1) week according to facility policy and procedure. 2. Providing care/treatment/services to strengthen lungs due to history of recurring pneumonia (infection of the lungs). As a result of these deficient practices, Resident 30 had the potential to have a relapse in pneumonia. A review of Resident 30's Admission Record, indicated the facility originally admitted Resident 30 on 3/12/2023 and readmitted on [DATE]. Resident 30's admitting diagnoses included but were not limited to: pneumonia (an infection of the lungs), type 2 diabetes mellitus (a metabolic disorder where the pancreas cannot produce enough insulin to digest sugars properly, causing high blood sugar that damages organs over time if not controlled), sepsis (infection of the blood) due to streptococcus pneumoniae (a bacteria often the cause of pneumonia), and asthma (a respiratory condition marked by spasms in the bronchi of the lungs, causing difficulty in breathing as a result of an allergic reaction). A review of Resident 30's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 3/1/2024, indicated Resident 30 was moderately cognitively impaired (impaired ability to think and reason), and had required moderate assistance (helper does less than half the effort) for rolling from left to right when turning or repositioning in bed. The MDS further indicated Resident 30 was non-ambulatory and required maximal assistance (helper does more than half the effort) for getting out of bed to chair or from lying to sitting in bed. A review of Resident 30's History and Physical (H&P), dated 3/5/2024, indicated Resident 30 had capacity to understand and make decisions. A review of Resident 30's Physician Orders, dated 12/27/2023, indicated Resident 30 had a completed order for Levaquin (an antibiotic) Oral Tablet 250 milligrams ([mg] a unit of measurement), two (2) tablets by mouth one time only for right upper lobe infiltrate (infection of the right upper lung). A review of Resident 30's nursing progress note, dated 1/10/2024, indicated Resident 30 had a non-productive cough and congestion. A review of Resident 30's Physician Orders, dated 4/21/2024, indicated Resident 30 had an active order for oxygen two (2) liters ([L] a unit of measurement) per minute via nasal cannula (a tubing device that fits into the nostrils to delivery oxygen) as needed for shortness of breath or oxygen saturation (how much oxygen is in the blood) less than 95% on room air (normal value is 92% to 100%). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 30's Physician Orders, dated 5/3/20234, indicated Resident 30 had a completed order for Levaquin Oral Tablet 750 mg, by mouth one time for pneumonia for three (3) days. A review of Resident 30's nursing progress note, dated 5/5/2024, indicated Resident 30 had complained of chest tightness and difficulty breathing with oxygen. A review of Resident 30's Physician Orders, dated 5/11/2024, indicated Resident 30 had an active order for Ipratropium-Albuterol Inhalation Solution (an inhalant that opens the airway) 0.5-2.5 milligrams ([mg]a unit of measurement) per 3 milliliters ([ml] a unit of measurement), to be inhaled orally every six (6) hours as needed for pneumonia. During an observation on 5/13/2024, at 11:43 a.m., Resident 30's oxygen tubing was dated 4/26/2024, and her humidifier was dated 4/30/2024. During an interview on 5/15/2024, at 10:17 a.m., with Registered Nurse (RN 1), RN 1 stated oxygen tubing and humidifiers must be dated and were changed every 2 days but per facility policy at least once a week to prevent infection. RN 1 stated Resident 30 had a history of and was recently treated for pneumonia on 5/1/2024. During an interview on 5/15/2024, at 3:42 p.m., with the Director of Nursing (DON), the DON stated they encourage Resident 30 to get out of bed to help her lungs but Resident 30 had periods of refusal. The DON stated she was unable to produce documentation of Resident 30's refusal of care such as getting out of bed to promote lung expansion (occurs during inhalation and is the process in which the lungs increase in volume to accommodate inhaled air). During an interview on 5/16/2024, at 11:33 a.m., with the DON, the DON stated oxygen tubing and humidifiers had to be changed at least once weekly or more as needed to prevent potential infection, and since Resident 30 had a history of pneumonia it made her vulnerable to becoming infected again. A review of facility policy and procedure (P&P) titled Requesting, Refusing and/or Discontinuing Care of Treatment, dated 12/2016, indicated if a resident refuses care or treatment the Charge Nurse, or Director of Nursing Services, or Interdisciplinary Team (IDT) will meet with the resident to: a. Determine why the resident is refusing care or treatment. b. Try to address the resident's concerns and discuss alternative options. c. Discuss the potential outcomes or consequences of the residents' decision. A review of facility policy and procedure (P&P) titled Oxygen Administration and Storage, dated 10/2023, indicated the purpose of the procedure was to provide guidelines for safe oxygen administration and storage, and all oxygen/respiratory supplies will be replaced every seven (7) days and as needed by facility staff.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47679 47858 45382 Based on interview and record review, the facility failed to ensure an Interdisciplinary Team Meeting (meeting with a group of healthcare professionals with various areas of expertise who work together towards the goals of the residents) records were completed, organized, and readily accessible for three of three sampled residents (Resident 64, 78, and 194). These deficient practices resulted in staff being unaware where Resident 64, 78, and 194's medical records were located and had the potential to delay and negatively affect the delivery of necessary care and services. Findings: a. A review of Resident 194's Admission Record (Face Sheet), Resident 194 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included but not limited to, traumatic subarachnoid hemorrhage (bleeding in the space between brain and the surrounding membrane), end stage renal disease ([ESRD], a stage where the kidneys can no longer support the body's needs for waste removal and fluid balance), and type two (2) diabetes mellitus (a condition that results in too much sugar circulating in the blood). A review of Resident 194's Minimum Data Set (MDS, a standardized resident assessment and screening tool), dated 4/30/2024, the MDS indicated Resident 194 was able to understand and be understood by others. The MDS indicated Resident 194's cognition (process of thinking) was intact. The MDS indicated Resident 194 had impairment (weakened or damaged function) on both sides of his lower extremities (lower part of the body that included the hip, knee, ankle, and foot). The MDS indicated Resident 194 requires supervision when eating. The MDS indicated Resident 194 required moderate assistance (requires assistance from helper, who provides less than half the effort) with oral hygiene. The MDS indicated Resident 194 required maximal assistance (requires assistance from helper, who provides more than half the effort) with toileting, bathing, dressing, and rolling left and right on the bed. A review of Resident 194's History and Physical Examination (H&P), dated 5/13/2024, the H&P indicated Resident 194 had the capacity to understand and make decisions. A review of Resident 194's Fall Risk Assessment, dated 4/26/2024 and 5/10/2024, the Fall Risk Assessment indicated Resident 194 was at a high risk for falls. A review of Resident 194's Situation Background Assessment Recommendation (SBAR) Form, dated 5/4/2024, the SBAR indicated Resident 194 had an unwitnessed fall on 5/4/2024 from his bed to the floor and sustained a bump with a laceration (cut) above his left eyebrow. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. A review of Resident 64's, Admission Record, indicated Resident 64 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included history of falling, fracture of the neck of the left femur (broken left hip bone), muscle weakness, hemiplegia (muscle weakness affecting one side of the body) and hemiparesis (muscle weakness affecting one side of the body) following cerebral infarction (disruption of blood flow in the brain) affecting the right dominant side, and epilepsy (uncontrollable brain activity that affects the function of the body). A review of Resident 64 's MDS, dated [DATE], indicated Resident 64's cognitive skills (mental action or process of acquiring knowledge and understanding) was severely impaired. The MDS indicated Resident 64 required substantial or maximal assistance (patient performance of 25% of a task and care giver assists with 75%) when transferring to the toilet, sitting to standing, and moderate assistance walking 10 feet. A review of Resident 64's Situation Background Assessment Recommendation (SBAR) note, dated 4/10/2024, indicated Resident 64 suffered an unwitnessed fall and Resident was noted on the floor in front of [the] roommate's bed near the door . She was found on floor lying on her left side. Resident 64 ambulated without assistance and the call light was in reach, near her wheelchair left side of her bed. The SBAR note indicated Resident 64 complained of 10/10 pain to her left leg and was sent to the General Acute Care Hospital (GACH). A review of Resident 64's Fall Risk assessment dated [DATE] (date of readmission) indicated Resident 64 was at high risk for falls. During an interview on 5/15/2024 at 12:27 p.m. with the Registered Nurse (RN 2), RN 2 stated an IDT meeting was held post-fall to discuss the causation of the fall and the necessary interventions to prevent further falls. RN 2 stated they have an IDT Conference Record on the electronic health record (EHR), but they also have handwritten IDT Conference Record when they meet after a fall. During a concurrent interview and record review on 5/15/2024 at 1:50 p.m., with RN1, Resident 194's Interdisciplinary Post Event Review dated 5/6/2024 and Resident 64's IDT Conference Record dated 3/14/2024 were reviewed. RN 1 stated any handwritten IDT Conference Records were in the Medical Records Department and were not kept in the residents' charts. During an interview on 5/15/2024 at 2:18 p.m., with the Medical Records Director (MRD), the MRD stated Resident 194's Interdisciplinary Post Event Review and Resident 64's IDT Conference Record were in a separate binder that held all the IDT Conference Records in the Nurses' Station and were not held in the Medical Records Department. c. A review of Resident 78's Admission Record indicated Resident 78 was admitted to the facility on [DATE] with diagnoses including spinal stenosis (condition that occurs when the spaces in the spine narrow and put pressure on the spinal cord and nerve roots), peripheral autonomic neuropathy (disorder that affects then nerves that control the body's processes without conscious effort), and malignant neoplasms (cancerous tumors) of the bladder and kidney. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 78's MDS, dated [DATE], the MDS indicated Resident 78 was cognitively intact. The MDS indicated Resident 78 was independent in eating, hygiene, toileting, bathing, and transfers and required supervision or touching assistance for walking 150 feet. The MDS indicated Resident 78 had no functional limitations in range of motion (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in both arms (shoulder, elbow, wrist, hand) and both legs (hip, knee, ankle, foot). During an interview on 5/14/2024 at 12:51 p.m. with Resident 78, Resident 78 stated he no longer had Restorative Nursing Aide services ([RNA] nursing aide program that helps residents maintain their function and joint mobility) to assist with exercises and walking and did not know why. During an interview on 5/15/2024 at 1:50 p.m. with the Director of Rehabilitation (DOR), the DOR stated Resident 78 was discharged from RNA services in 2023 due to multiple refusals. The DOR stated an IDT meeting should have been conducted with Resident 78 when he was discharged from RNA services but was unsure if it was done. The DOR stated she would check Resident 78's medical record to locate an IDT meeting note indicating staff discussed discontinuation of RNA services with Resident 78. During an interview on 5/15/2024 at 3:20 p.m. with the DOR, the DOR stated she reviewed Resident 78's physical chart and electronic record and could not locate an IDT meeting note indicating staff discussed discontinuation of RNA services with Resident 78. During an interview on 5/15/2024 at 3:55 p.m., the MRD, the MRD stated she provided all the IDT meeting notes she was able to locate in Resident 78's physical chart and electronic record, however, there was no IDT meeting note addressing Resident 78's discontinuation of RNA services. During a concurrent interview and record review on 5/16/2024 at 12:53 p.m. with the DON and Director of Staff Development (DSD), the DON and DSD both stated they located Resident 78's IDT meeting note, dated 11/15/2023, indicating staff discussed discontinuation of RNA services with Resident 78 in a stack of papers in the DSD's office. The DSD and DON stated all IDT meeting notes should either be in Resident 78's physical chart, the Falls binder (records containing documents related to falls), or electronic record and not in a stack of papers in the DSD's office. The DSD stated she was very disorganized and had stacks of papers, including medical records, scattered in unorganized piles throughout her office. The DSD stated she tended to obtain or complete a medical record document, put it on her desk, and forget to file it in either the physical chart or upload it into the electronic record. The DSD and DON stated they were unsure if other IDT meeting notes were missing or misplaced because the DSD had a lot of medical record documents on her desk that were not filed into the physical chart or uploaded in the electronic record. The DSD stated if medical records were unorganized and not readily available, it could potentially lead to lost documents, incomplete medical records, and lack of evidence indicating care or services were provided. During an interview on 5/16/2024 at 3:30 p.m. with the MRD, the MRD stated all IDT notes should either be in the resident's physical chart under the MDS tab, in the Falls binder, or uploaded into the electronic record. The MRD stated the facility needed an organized and centralized way of accessing documents because the medical records were in so many different areas in the facility and staff did not know how and where to access them. The MRD stated if medical records were unorganized and not readily available, it could potentially lead to an incomplete medial record, lost documents, and confusion and inability to access the medical record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/16/2024 at 3:54 p.m. with the DON, the DON stated all medical records should be organized and readily available. The DON stated the IDT meeting notes should either be in the physical chart, fall binder, overflow charts, or in the electronic record and not stored loosely in the DSD's office in a stack of papers. The DON stated the facility had instances in the past where parts of the resident's medical records were lost or misplaced due to lack of organization. The DON stated the disorganization of medical records was an issue for the facility that needed to be fixed. The DON stated that if medical records were unorganized and not readily available, it could potentially lead to a delay in care and services, an incomplete medical record, confusion of how and where to access the medical record, and lost documents. A review of the facility's Policy and Procedure (P&P), titled, Location and Storage of Medical Records, revised 12/2006, The P&P indicated the facility maintained a hybrid health record system that included both paper and electronic documents where all resident information was maintained. The P&P indicated the facility maintained a hard-chart health record at the nursing station to include paper-based health records that were not electronically maintained.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45382 Based on observation, interview, and record review, the facility failed to implement and maintain infection control procedures for one of six sampled residents (Resident 36) when the Restorative Nursing Aide 1 (RNA 1) did not clean and disinfect shared resident equipment, a front wheeled walker ([FWW] mobility device with two wheels in the front used for support when standing or walking), after resident use and before placing the FWW into the Utility Room with other clean equipment. This deficient practice had the potential to result in the spread of infection to facility staff, residents, and visitors. Findings: A review of Resident 36's Admission Record indicated Resident 36 was admitted to the facility on [DATE] and readmitted the resident on 12/10/2023 with diagnoses including muscle weakness, acquired absence of the left leg above the knee (amputation of the leg above the level of the knee), and ischemic heart disease (damage or disease in the heart's major blood vessels). During an observation on 5/15/2024 at 11:40 a.m. in the hallway with RNA 1 and RNA 2, both were observed completing walking exercises with Resident 36 in the hallway using a FWW. At the end of the session, RNA 1 folded the FWW, walked to the Utility Room (storage room) holding the FWW, placed the FWW in the Utility Room, closed the door, and walked to the nurse's station. RNA 1 did not clean and disinfect the FWW after using the device with Resident 36 and before placing the FWW into the Utility Room. During an interview on 5/15/2024 at 11:52 a.m. with RNA 1, RNA 1 stated shared equipment such as FWWs were stored in the Utility Room for all staff to use with the residents. RNA 1 stated all shared equipment must be disinfected in between resident use and before being placed into the Utility Room because only clean equipment was stored in the Utility Room. RNA 1 confirmed he did not clean and disinfect the FWW after he used it with Resident 36 and before placing the FWW into the Utility Room. RNA 1 stated it was important to clean and disinfect shared equipment in between resident use to prevent the spread of infection. RNA 1 stated he should have disinfected the FWW after using the equipment with Resident 36 and before placing it in the Utility Room because staff could unknowingly use a contaminated FWW and spread infection. During an interview on 5/15/2024 at 2:44 p.m. with the Infection Preventionist Nurse (IPN), the IPN stated all shared resident equipment should be cleaned and disinfected in between resident use and before being placed into the Utility Room. The IPN stated shared resident equipment such as walkers were stored in the Utility Room and should always be cleaned and disinfected before being placed into the Utility Room since all equipment in the room was clean. The IPN stated if shared resident equipment was not cleaned and disinfected appropriately in between resident use, it could lead to the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/16/2024 at 11:43 p.m. with the Director of Nursing (DON), the DON stated all shared resident equipment should be cleaned and disinfected in between and after resident use. The DON stated the Utility Room stored only clean equipment and all equipment should be disinfected before being placed back into the Utility Room. The DON stated it was important shared resident equipment was cleaned and disinfected in between resident use and before placing the equipment back into the Utility Room to prevent the spread of infection. During a review of the facility's Policy and Procedure (P&P), titled, Cleaning and Disinfection of Resident-Care Items and Equipment, undated the P&P indicated resident care equipment, including reusable items and durable medical equipment (DME) would be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard. The P&P indicated DME or other shared equipment must be cleaned and disinfected before reuse by another resident. The P/P indicated reusable resident care equipment such as walkers would be decontaminated and/or sterilized between residents.

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F 0907 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough space and equipment to meet each resident's needs 45382 Based on observation, interview, and record review, the facility failed to ensure the therapy mat (an adjustable padded surface used for therapy treatment) in the rehabilitation room was clear of miscellaneous items including a black bag, office supplies, a large black mat, a large therapy ball (large inflatable ball used for exercise), a graded rainbow arc (device used in therapy to assist with arm exercises), two bins containing multiple balls, a foam roller, a backpack, two large cardboard boxes, and four plastic bins containing various items to ensure adequate space was available for resident use during therapy treatments. This deficient practice had the potential to minimize equipment use and usable treatment space for residents during therapy. Findings: During an observation in the rehabilitation gym on 5/14/2024 at 12:49 p.m. during the recertification survey, a black bag, office supplies, a large black mat, a large therapy ball, a graded rainbow arc, two bins containing multiple balls, a foam roller, a backpack, two large cardboard boxes, and four plastic bins containing miscellaneous items were observed on top of the therapy mat. During an observation and interview on 5/14/2024 at 3:16 p.m. with the DOR , the DOR stated, the therapy mat was used for residents who had trouble standing and sitting. The DOR confirmed there was black bag, office supplies, a large black mat, a large therapy ball, a graded rainbow arc, two bins containing multiple balls, a foam roller, a backpack, two large cardboard boxes, and four plastic bins containing staff's personal items and therapy equipment. The DOR stated there should not be any items on the therapy mat because the mat was used for therapy treatment with residents. The DOR stated the items were on the therapy mat because there was no more storage space in the rehabilitation gym and the designated storage area outside the rehabilitation gym was also full. During a review of the facility's Policy and Procedures (P&P), revised February 2009, titled, Therapy Department Supplies and Equipment, Maintenance, indicated equipment must be ready for use to serve the resident's needs. The P&P indicated the therapy department supplied and equipment would be properly stored in designated locations.