STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056117	A. Building B. Wing	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rowland	330 W. Rowland Street Covina, CA 91723

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on interview and record review the facility failed to follow the facility's policy on Advance Directives (AD, a legal document that informs healthcare providers what kind of care a person would want to receive if the individual was unable to speak for self) to ensure a current copy of a resident's AD was in the medical chart for one of three sampled resident (Resident 288). This failure had the potential for Resident 288's AD to not be followed by the facility staff. Findings: During a review of Resident 288's Admission Record (AR), the AR indicated Resident 288 was admitted to the facility on [DATE] with diagnoses that included urinary tract infection (UTI, occurs when bacteria enters the urethra [tube through which urine leaves the body] and multiply), hyperlipidemia (high levels of cholesterol in the blood), and constipation (stool becomes hard and difficult to pass). During a review of Resident 288's History and Physical (H&P, formal document of a medical provider's examination of a patient) dated 5/8/2024, the H&P indicated Resident 288 was alert and oriented to person, place, and time. The H&P indicated Resident 288 had both an Advance Directive and Physician Orders for Life Sustaining Treatment (POLST, form completed by a physician that gives people with serious illnesses control over own care by specifying types of medical treatment the individual would want to receive during serious illness. A POLST does not replace an AD but provides guidance for healthcare providers in the case of an emergency). During a review of Resident 288's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 5/20/2024, the MDS indicated Resident 288's cognitive abilities (ability to think, learn, and process information) were intact. During a review of Resident 288's Advance Directive/POLST Acknowledgement form (ADPA), dated 5/8/2024, the ADPA form indicated Resident 288 had executed an AD or POLST form and AD was circled out in the ADPA form. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/5/2024 at 11:14 AM with the Social Services Director (SSD), Resident 288's ADPA form was reviewed. The ADPA form indicated Resident 288 had executed an AD or a POLST form. SSD stated the ADPA form for Resident 288 was not specific if the resident had an AD or a POLST. SSD stated the ADPA form should be specific because the resident's AD form could be missed. SSD stated a current copy of the AD form was not in Resident 288's medical chart and only a copy of the POLST was listed in the medical chart. SSD stated the risk of not having a current copy of the AD was that the wishes of the resident would not be respected if the AD was different from the POLST. SSD stated the ADPA form should specify if the resident had a POLST or AD so staff could inform the resident of the right to create an AD. During an interview on 6/10/2024 at 11:33 AM with the Director of Nursing (DON), the DON stated an AD needed to be placed in the front of each resident's medical chart. The DON stated if the AD was not placed in Resident 288's chart, the risk was that Resident 288's wishes would not be honored. During a review of the facility's undated policy and procedure (P&P) titled, Advance Directives the P&P indicated prior to or upon admission of a resident, the SSD or designee will inquire of the resident, his/her family members and or his or her legal representatives about the existence of any written advance directives. The P&P indicated information about whether the resident has executed an AD shall be displayed prominently in the medical record.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 40913 Based on observation, interview, and record review, the facility failed to provide privacy during a bed bath to one of one sampled resident (Resident 28.) This deficient practice had the potential to cause embarrassment and lowered self-esteem for Resident 28. Findings: During a review of Resident 28's Admission Record (AR), the AR indicated the facility admitted the resident on 12/10/2023, with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning) and epilepsy (brain disorder in which a person has repeated seizures (convulsions) over time). During a review of Resident 28's Minimum Data Set (MDS - a standardized assessment and care planning tool) dated 1/24/2024, the MDS indicated the resident had moderately impaired cognition (ability to understand). The MDS indicated Resident 28 was dependent with showers, self-bathing and toileting and required moderate (helper does less than half the effort) assistance with bed mobility. During an observation on 6/4/2024 at 10:03 am to 10:30 am, Certified Nursing Assistant 6 (CNA 6) gave Resident 28 a bed bath. CNA 6 started the procedure by removing Resident 28's clothes. There was a blanket covering the lower part of the resident's body. CNA 6 washed Resident 28's face, neck, chest, abdomen and under the breast and dried the areas with a towel. CNA 6 then removed the blanket covering the lower part of the resident's body and removed Resident 28's adult brief. Resident 28's upper body was not covered while CNA 6 washed the resident's perineal area using the same water used to wash Resident 28's upper body. Resident 28 was still not covered when CNA 6 asked Resident 28 to turn to wash the resident's back. Resident 28 was still not covered when another CNA entered the room to go to Resident 28's roommate's bed. The privacy curtain separating Resident 28 and Resident 28's roommate was open. During an interview on 6/4/2024 at 10:31 am, CNA 6 stated Resident 28 was exposed during the time CNA 6 washed other areas of Resident 28's body and when another CNA entered the room. CNA 6 stated she needed to close the curtain on the other side even if the roommate was not present so Resident 28 would not be exposed in case someone entered the room. During a review of the facility's undated Policy and Procedure (P&P) titled Giving a Bed Bath, the P&P indicated to wash only one part of the body at a time. Wash, rinse, and dry each part well. Cover each area as you complete the procedure. The P&P indicated to change the bath water as often as necessary during the bath, before washing the legs, back and

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. 48905 Based on interview and record review, the facility failed to transmit assessments within 14 days of completion for 23 of 23 sampled residents (Residents 1, 4, 17, 21, 22, 26, 28, 29, 31, 33, 35, 41, 49, 52, 56, 61, 62, 70, 71, 72, 78, 79, and 80). This failure had the potential to result in inaccurate facility information submitted to the Centers for Medicare and Medicaid Services (CMS, federal agency that works with the health care community to improve quality, equity, and outcomes in the health care system) and would affect the quality of care to the residents. Findings: During record review of the Minimum Data Set (MDS, a standardized assessment and care planning tool) 3.0 Final Validation Report, the MDS 3.0 Final Validation Report indicated it was submitted on 6/6/2024 for Residents 1, 4, 17, 21, 22, 26, 28, 29, 31, 33, 35, 41, 49, 52, 56, 61, 62, 70, 71, 72, 78, 79, and 80. During an interview on 6/6/2024 at 8:46 AM with the MDS Nurse, the MDS Nurse stated the Assistant Administrator (AADM) was responsible for transmitting the MDS assessments to CMS. During an interview on 6/6/2024 at 9:22 AM with the AADM, the AADM stated the AADM was part of the MDS staff and stated MDS assessments for 23 residents (Residents 1, 4, 17, 21, 22, 26, 28, 29, 31, 33, 35, 41, 49, 52, 56, 61, 62, 70, 71, 72, 78, 79, and 80) were not transmitted within the 14 days of completion. The AADM stated each resident would have a different due date based on the type of assessment. The AADM stated the risk of not submitting the MDS assessments timely would create inaccurate information and could affect the facility star rating and quality. AADM stated the AADM did not realize the MDS assessments were due for 23 residents and missed the transmission due dates. During an interview on 6/6/2024 at 1:28 PM with the AADM, the AADM stated the facility has not trained other MDS staff on how to transmit MDS assessments to CMS. During a review of the facility's undated policy and procedure (P&P), the P&P indicated MDS staff were responsible for transmitting MDS data timely in accordance with the MDS RAI Instruction Manual.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 48905 Based on observation, interview, and record review, the facility failed implement its policy and procedure (P&P) on Translation and Interpretation services to ensure needs and questions from the resident with limited English proficiency (LEP) were addressed by staff for one of one sampled resident (Resident 289). This failure had the potential to not meet Resident 289's needs. Findings: During a review of Resident's 289 Admission Record (AR) the AR indicated the facility admitted Resident 289 on 5/10/2024 with diagnoses that included wedge compression fracture (bone in front of the spine collapsing forming a wedge shape) of first lumbar vertebra (bones in spine to provide support to the body), unspecified hearing loss, and a history of falling. During a review of Resident 289's History and Physical (H&P, a formal document of a medical provider's examination of a patient) dated 5/11/2024, the H&P indicated Resident 289 had the capacity to understand and make decisions. During a review of Resident 289's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 5/17/2024, the MDS indicated Resident 289's preferred language was Chinese. During a review of Resident 289's untitled care plan (CP), dated 5/11/2024, the CP indicated Resident 289 had a communication problem related to being hard of hearing. The CP intervention indicated for staff to assess for adequate communication. During a concurrent observation and interview on 6/4/2024 at 10:29 AM with Licensed Vocational Nurse 1 (LVN 1) in Resident 289's room, Resident 289 called out in Spanish, Enfermera as LVN 1 walked out of Resident 289's room. LVN 1 stated Resident 289 was calling for a family member and stated Resident 289 spoke Chinese and Spanish languages. LVN 1 stated LVN 1 pointed to body parts to communicate to Resident 289 when passing medications. LVN 1 stated there was no way to ensure Resident 289 would understand the purpose of the medication if LVN 1 pointed to various body parts. LVN 1 stated there was no communication board at the bedside to communicate simple phrases to Resident 289. LVN 1 stated Resident 289's need would not be met if there were no tools to help communicate with the resident in a language the resident can understand. During an interview on 6/6/2024 at 9:32 AM with the Activities Director (AD), the AD stated the facility had four communication boards in Spanish, Arabic, Filipino, and Mandarin. The AD stated the AD was responsible for passing out the boards to residents who cannot communicate in English and the communication boards needed to be at the bedside. The AD stated residents and staff would not be able to communicate with each other and resident's needs would not be met if the communication boards were not at the bedside, readily available to use. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's undated P&P titled, Translation and/or Interpretation of Facility Services the P&P indicated the facility would ensure that individuals with LEP would have meaningful access to information and services provided by the facility. The P&P indicated the facility required LEP resident's needs and questions were accurately communicated to the staff.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 48905 Based on observation, interview, and record review, the facility failed to answer the call light and provide assistance to a resident in a timely manner in accordance with the resident's care plan (CP) and the facility's Policy and Procedure (P&P) on answering call lights, for one of one sampled resident (Resident 289). This failure had the potential to result in fall or injury to Resident 289 who had a history of falling. Findings: During a review of Resident's 289 Admission Record (AR) the AR indicated the facility admitted Resident 289 on 5/10/2024 with diagnoses that included wedge compression fracture (bone in front of the spine collapsing forming a wedge shape) of first lumbar vertebra (bones in spine to provide support to the body), unspecified hearing loss, and a history of falling. During a review of Resident 289's History and Physical (H&P, a formal document of a medical provider's examination of a patient) dated 5/11/2024, the H&P indicated Resident 289 had the capacity to understand and make decisions. During a review of Resident 289s untitled CP, dated 5/11/2024, the CP indicated Resident 289 required assistance in activities of daily living (ADL) and indicated for staff to provide help or assistance as needed. During a review of Resident 289's Minimum Data Set (MDS-a standardized assessment and care planning tool) dated 5/17/2024, the MDS indicated Resident 289 cognitive abilities (ability to think, learn, and process information) were intact. The MDS indicated Resident 289 required maximal assistance with sitting on the side of the bed and required moderate assistance with sit to stand and toilet transfers. During a concurrent observation and interview on 6/5/2024 at 9:55 AM with Resident 289 in Resident 289's room, the call light was observed to be on from 9:55 AM to 10:26 AM. Resident 289 stated Resident 289 needed help to use the restroom and had been waiting for a long time for staff to come. Resident 289 stated a nurse (unidentified) came inside her room and did not come back to assist Resident 289 to the restroom. During an interview on 6/5/2024 at 10:59 AM with Certified Nursing Assistant 5 (CNA 5), CNA 5 stated call lights needed to be answered as soon as possible. CNA 5 stated it was not acceptable for residents to wait 30 minutes for assistance to use the restroom. CNA 5 stated the risk of not responding to call lights in a timely manner was that the resident could get up to use the restroom and the resident could fall or sustain an injury. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/5/2024 at 9:44 AM with the Registered Nurse Supervisor 1 (RN Sup1), RN Sup 1 stated if the resident's call light was on, staff needed to check on the resident and respond within three to five minutes. RN Sup 1 stated it was not acceptable if Resident 289 waited 30 minutes for assistance to use the restroom. RN Sup 1 stated Resident 289 would get out of bed without assistance and fall if the resident's call light was not answered timely. During a review of the facility's undated P&P titled, Call Light, the P&P indicated CNA's and Licensed Nurses were trained to always answer call lights courteously within five to six minutes of the call light being activated.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40913 Based on observation, interview, and record review, the facility failed to ensure interventions were developed and implemented to address the resident's positioning preference for one of one sampled resident (Resident 16.) Resident 16 had a non-healing wound to the left lateral (side) ankle and left medial (middle) ankle and Resident 16 preferred to lie on the left side. This deficient practice had the potential to delay wound healing for Resident 16. Findings: During a review of Resident 16's Admission Record (AR), the AR indicated the facility admitted the resident on 7/27/2021 and readmitted on [DATE], with diagnoses that included benign neoplasm of endocrine pancreas (non-cancerous tumors of the pancreas) and infection and inflammatory reaction (pain, swelling, and discomfort) due to internal orthopedic prosthetic devices, implants, and grafts (medical devices or tissues placed inside or on the surface of the body). During a review of Resident 16's Minimum Data Set (MDS - a standardized assessment and care planning tool) dated 8/4/2023, the MDS indicated the resident had moderate cognitive (ability to understand) impairment. The MDS indicated Resident 16 was totally dependent with toilet use and required extensive assistance (resident involved in activity, staff provide weight-bearing support) with bed mobility. The MDS indicated Resident 16 had open lesions on the foot with skin and ulcer/injury treatments including pressure reducing device for the bed, turning and repositioning program. During an observation on 6/4/2024, the following were observed: At 10:46 am, Resident 16 was asleep on her back with her legs curled upwards to the waist with the legs towards the left side. At 12:40 pm, Resident 16 was facing the left side. At 1:10 pm, Resident 16 was facing the left side. At 2:45 pm, Resident 16 was facing the left side. During an observation on 6/5/2024, the following were observed: At 8:50 am, Resident 16 had a pillow on resident's left side and Resident 16 was facing the left side. At 11:16 am, Resident 16 had a pillow on resident's right side and Resident 16 was facing the left side. At 1:00 pm, Resident 16 had a pillow on the resident's right side and Resident 16 was facing the left side. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 2:37 pm, Resident 16 had a pillow on resident's right side and Resident 16 was facing the left side. During an interview on 6/6/2024 at 2:50 pm with Certified Nursing Assistant 6 (CNA 6), CNA 6 stated she would reposition the resident to the right side, but Resident 16 would go back to stay on the left side. CNA 6 stated Resident 16 preferred to lie on the left side. CNA 6 stated other CNAs also confirmed Resident 16 preferred to lie on her left side. During an observation on 6/7/2024 at 8:22 am, CNA 5 and RNA 2 provided incontinent (management for incontinence [inability to control urine or stool]) care to Resident 16. Resident 16 tolerated turning to her right side with no signs and symptoms of pain. There was an intact dressing to the left lateral ankle and left medial ankle. During a concurrent observation and interview on 6/7/2024 at 4:38 pm, Registered Nurse Supervisor 2 (RN Sup 2) removed the pillow positioned on Resident 16's left side. Resident 16 was still positioned towards the left side. RN Sup 2 stated Resident 16 would still position herself towards the left side because that was her preference. RN Sup stated staff should position the resident to a different position other than the left side. RN Sup 2 stated the facility needed to use other alternatives to position Resident 16 to face the right side or supine such as using two pillows instead of just one pillow or using other positioning device such as bolsters to keep her off the left side most of the time. During a wound observation on 6/10/2024 at 8:39 am, there was an open wound to the left lateral and left medial ankle with a metal visible from inside the wound. During an interview on 6/10/2024 at 3:05 pm, the Wound Care Nurse (WCN) stated Resident 16 needed to be repositioned and not lie on the left side all the time. WCN stated Resident 16 needed to get up to the chair more often instead of lying in bed most of the time and offload the area where the wound was located. The WCN stated Resident 16 preferred to stay on her left side. The WCN did not respond when asked what would happen to the wound if Resident 16 was lying on one side for an extended period of time. During a review of Resident 16's untitled care plans, the care plans indicated the following: On 3/13/2022, Resident 16 had a left ankle open skin with interventions that included to offload foot. The care plan was resolved. On 10/13/2023, Resident 16 had an infected hardware on the resident's left lower extremity with interventions to administer antibiotics (medication to treat infection). On 11/30/2023, Resident 16 had left lateral and medial surgical wound. There were no interventions developed for Resident 16's preference to stay on the left side where the wound was located. On 2/25/2024, Resident 16 had an infected left lateral ankle. There were no interventions developed for Resident 16's preference to stay on the left side where the wound was located. On 5/29/2024, Resident 16 had a left medial ankle surgical wound. There were no interventions developed for Resident 16's preference to stay on the left side where the wound was located. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's undated Policy and Procedure (P&P) titled Wound Care, the P&P indicated to review the resident's care plan to assess for any special needs of the resident.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40913 Based on observation, interview, and record review, the facility failed to ensure care and services was provided to prevent pressure ulcer (lesion/wound caused by unrelieved pressure that results in damage of underlying tissue) for one of five sampled residents (Resident 16.) Resident 16 developed redness at the base of the left lateral toe and redness at the base of the right big toe. This deficient practice had the potential for the development of pressure ulcer. Cross Reference: F684 Findings: During a review of Resident 16's Admission Record (AR), the AR indicated the facility admitted the resident on 7/27/2021 and readmitted on [DATE], with diagnoses that included benign neoplasm of endocrine pancreas (non-cancerous tumors of the pancreas) and infection and inflammatory reaction (pain, swelling, and discomfort) due to internal orthopedic prosthetic devices, implants, and grafts (medical devices or tissues placed inside or on the surface of the body). During a review of Resident 16's Minimum Data Set (MDS - a standardized assessment and care planning tool) dated 8/4/2023, the MDS indicated the resident had moderate cognitive (ability to understand) impairment. The MDS indicated Resident 16 was totally dependent with toilet use and required extensive assistance (resident involved in activity, staff provide weight-bearing support) with bed mobility. The MDS indicated Resident 16 had open lesions on the foot with skin and ulcer/injury treatments including pressure reducing device for the bed, turning and repositioning program. During an observation on 6/4/2024, the following were observed: At 10:46 am, Resident 16 was asleep on her back with her legs curled upwards to the waist with the legs towards the left side. At 12:40 pm, Resident 16 was facing the left side. At 1:10 pm, Resident 16 was facing the left side. At 2:45 pm, Resident 16 was facing the left side. During an observation on 6/5/2024, the following were observed: At 8:50 am, Resident 16 had a pillow on resident's left side and Resident 16 was facing the left side. At 11:16 am, Resident 16 had a pillow on resident's right side and Resident 16 was facing the left side. (continued on next page)

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The Rowland	330 W. Rowland Street Covina, CA 91723

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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	At 1:00 pm, Resident 16 had a pillow on the resident's right side and Resident 16 was facing the left side. At 2:37 pm, Resident 16 had a pillow on resident's right side and Resident 16 was facing the left side. During an interview on 6/6/2024 at 2:50 pm with Certified Nursing Assistant 6 (CNA 6), CNA 6 stated she would reposition the resident to the right side, but Resident 16 would go back to stay on the left side. CNA 6 stated Resident 16 preferred to lie on the left side. CNA 6 stated other CNAs also confirmed Resident 16 preferred to lie on her left side. During an observation on 6/7/2024 at 8:22 am, CNA 5 and RNA 2 provided incontinent (management for incontinence [inability to control urine or stool]) care to Resident 16. Resident 16 tolerated turning to her right side with no signs and symptoms of pain. There was redness at the base of the left lateral toe and the base of the right big toe of Resident 16. During a concurrent observation and interview on 6/7/2024 at 4:38 pm, Registered Nurse Supervisor 2 (RN Sup 2) removed the pillow positioned on Resident 16's left side. Resident 16 was still positioned towards the left side. RN Sup 2 stated Resident 16 would still position herself towards the left side because that was her preference. RN Sup stated staff should position the resident to a different position other than the left side. There was blanchable redness at the base of the left lateral toe and the base of the right big toe of Resident 16. During an interview on 6/10/2024 at 3:05 pm, the Wound Care Nurse (WCN) stated Resident 16 needed to be repositioned and not lie on the left side all the time. WCN stated Resident 16 needed to get up to the chair more often instead of lying in bed most of the time and offload the area where the wound was located. The WCN stated Resident 16 preferred to stay on her left side. The WCN did not respond when asked what would happen to the wound if Resident 16 was lying on one side for an extended period of time. During a review of the facility's undated Policy and Procedure (P&P) titled Prevention of Pressure Ulcers, the P&P indicated pressure ulcers were usually formed when a resident remained in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area and subsequent destruction of tissue. The most common site of a pressure ulcer was where the bone was near the surface of the body including the back of the head, around the ears, elbows, shoulder blades, backbone, hips, knees, heels, ankles, and toes. For a person in bed, change position at least every two hours or more frequently if needed. For residents with a risk factor of lowered mental awareness, choose preventive actions appropriate to individual risk factors and adjust for cognitive impairment of the resident, adjust for any limitations in resident's understanding of instructions or ability to participate in preventive actions.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on interview and record review, the facility failed to follow its policy and procedure (P&P) on Restorative Services (care designed to improve or maintain the functional ability of residents) to provide restorative services in accordance with Medical Doctor's (MD-physician) order for one of four sampled residents (Resident 2). This failure had the potential to result in a decrease in range of motion (ROM, full movement potential of a joint [where two bones meet]) in Resident 2's bilateral (both) legs. Findings: During a review of Resident 2's Admission Record (AR), the AR indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included spinal stenosis (narrowing of spinal canal in lower part of the back) of the lumbar region (lower part of the back) and bilateral artificial knee joints. During a review of Resident 2's untitled Care Plan (CP) dated 8/6/2021, the CP indicated Resident 2 required variable assistance with activities of daily living (ADL, basic tasks that include eating, dressing, getting in or out of bed or a chair, taking a bath or shower, and using the toilet). The CP indicated for the RNA to ambulate Resident 2 daily, five times a week as tolerated. During a review of Resident 2's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 3/30/2024, the MDS indicated Resident 2's cognitive abilities (ability to think, learn, and process information) were intact. The MDS indicated Resident 2 used a wheelchair and required moderate assistance with walking. During a review of Resident 2's Order Details (OD) dated 6/21/2023 at 5:12 PM, the OD indicated Resident 2 had MD order for Restorative Nursing Assistant (RNA, performs transfers, bed mobility, positioning, ROM, and general strengthening exercises) program for ambulation (walking) every five days a week. The OD indicated one time a day every Monday, Tuesday, Wednesday, Thursday, and Friday. During a concurrent interview and record review on 6/7/2024 at 7:54 AM with Restorative Nursing Aide (help residents maintain their function and mobility) 1 (RNA 1), Resident 2's Treatment Administration Record (TAR) dated 5/2024 was reviewed. Resident 2's TAR indicated blank spaces for RNA program for ambulation on 5/2/2024, 5/13/2024, 5/21/2024, and 5/27/2024. RNA 1 stated the blank spaces in Resident 2's TAR indicated treatment was not performed. RNA 1 stated if the resident refused it would be documented as refused. RNA 1 stated the risk of not performing treatment as ordered was that there could be a decrease in Resident 2's ROM and not following MD's orders. During an interview on 6/10/2024 at 11:31 AM with the Director of Nursing, the DON stated blank spaces in Resident 2's TAR on 5/2/2024, 5/13/2024, 5/21/2024, and 5/27/2024 indicated the task was not completed. The DON stated, not performing RNA exercises per MD order placed the resident at risk for contractures (permanent stiffness in a joint) or a decline in ADL function. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled Restorative Services, the P&P indicated staff to assist residents to carry out the prescribed physical therapy exercises between visits of the physical therapist.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14330 Based on observation, interview, and record review, the facility failed to ensure residents had an environment free of accident hazards (risks) for two of four residents (Residents 8 and 36) who were smokers (tobacco users) by failing to: 1. Implement the facility's smoking policy titled, Smoking Policy-Residents, for Residents 8 and 36 who did not have smoking privileges to smoke with staff supervision, and for staff to keep Residents 8 and 36's smoking articles including cigarettes and cigarette lighters for Residents 8 and 36. 2. Implement the facility's smoking policy titled, Smoking Policy-Residents, to evaluate Resident 8's ability to smoke safely with the consultation from the facility's Director of Nursing (DON) and Resident 8's Attending Physician when safety restriction for smoking was needed in accordance with facility's Safe Smoking Evaluation Form. 3. Implement the facility's smoking policy titled, Smoking Policy-Residents, not to allow Resident 36 smoked in an area with an oxygen (gas needed for breathing, when combined with fuel, it released heat and generated combustion/ignition/fire) machine present in Resident 36's room. 4. Implement Resident 36's untitled Care Plan (CP), dated 5/25/2024 indicating not to allow Resident 36 to have cigarettes and lighters on her possession, and for Resident 36 to dispose cigarettes in the proper receptacle (facility's ashtrays). 5. Implement Resident 36's smoking intervention in Resident 36's Smoking Evaluation (SE) form, dated 3/27/2024 indicating Resident 36 had poor vision and required supervision when smoking. These failures had the potential for Resident 8 and Resident 36 to turn on the lighters, cause a fire that could affect the health, safety, and wellbeing of all 90 residents in the facility, facility staff and visitors and result in serious harm, injuries, hospitalization , and death. On 6/4/2024 at 5:15 pm, while onsite at the facility, the survey team called an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) situation regarding the facility's failure to ensure Residents 8 and 36, who were smokers, had an environment that was free of accident hazard by allowing both residents to have cigarettes and cigarette lighters in possession inside their rooms. Resident 8 was on Seroquel (an antipsychotic [medicine to treat mental illness] medication) for hearing voices telling him to hurt himself and others in the facility. Resident 36's roommate had an oxygen machine used whenever necessary (PRN) with a posted Danger sign in red color that indicated, Oxygen, No Smoking, No Open Flames posted outside Resident 36's room. The IJ was called in the presence of the facility's Administrator (ADM) and DON. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 6/6/2024, at 4:06 pm, the facility submitted an acceptable IJ Removal Plan ([IJRP] a plan with interventions to correct the deficient practice). While onsite at the facility, the survey team verified and confirmed the facility's implementation of the IJRP through observation, interview, and record review. The survey team determined an IJ situation was no longer present and removed the IJ situation on 6/6/2024 at 6:19 pm in the presence of the DON. A review of the IJRP included the following immediate actions: 1. On 6/4/2024, cigarettes and cigarette lighters were removed from Resident 8 and Resident 36's rooms and placed under supervision of the charge nurses (Licensed Vocational Nurses [LVNs] and Registered Nurses [RNs]). 2. On 6/4/2024, Resident 8 and Resident 36's CPs were updated by LVNs and the DON. 3. On 6/4/2024, Resident 8 and Resident 36 were educated by the facility's DON on smoking and cigarette lighter safety and why cigarette lighters cannot be in residents' possession. 4. On 6/4/2024, Resident 8 was informed by the ADM for safety and importance of using appropriate and approved ashtrays for cigarette butts (the part of the cigarette that was left after it had been smoked). 5. On 6/4/2024, the Supervised Designated Smoking Area Map for smokers was created which included the following: a. Patio in front of the facility by the front entrance. b. Patio outside the facility by the back entrance/parking lot. c. Patio outside the facility exit located between rooms [ROOM NUMBERS]. 6. On 6/4/2024, the Designated Smoking Time Schedule for residents who required smoking supervision was created which included the following: a. Morning after breakfast from: 8:00 am to 8:30 am, 9:00 am to 9:30 am and 11:30 am to 12:00 pm b. Afternoon after lunch from: 1:00 pm to 1:30 pm, 2:30 pm to 3:00 pm and 4:30 pm to 5:00 pm c. Evening after dinner from: 6:00 pm to 6:30 pm 7. On 6/4/2024, the Director of Staff Development (DSD) provided an in-service to 26 Certified Nursing Assistants (CNAs), nine LVNs, four RNs, one Social Services Designee, one Medical Records Designee, three activity staff, and one housekeeper on the facility's revised smoking policies regarding supervised smoking, designated smoking areas, and designated smoking time schedules. Findings: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	a. During a review of Resident 8's Admission Record (AR), the AR indicated the facility admitted Resident 8 on 8/6/2019 and readmitted on [DATE] with diagnoses that included diabetes mellitus (a disease in which the body does not control the amount of glucose (a type of sugar) in the blood and the kidneys make a large amount of urine), nicotine (chemical found in tobacco) dependence (an addiction to tobacco product) and paranoid schizophrenia (mental disorder characterized by abnormal social behavior and failure to understand what is real). During a review of Resident 8's Nurses Notes (NN) dated 5/22/2024, timed 7:46 pm, the NN indicated Resident 8 was transferred to General Acute Care Hospital 1 (GACH 1) emergency roiagnom on a 5150 (the number of the section of the Welfare and Institutions Code, which allows an adult who was experiencing a mental health crisis to be involuntarily detained for a 72- hour psychiatric hospitalization when evaluated to be a danger to others, or to himself or herself, or gravely disabled) hold due to confusion, agitation, wanting to commit suicide, threatening to kill the DON and threatening to blow up the hospital. During a review of Resident 8's Order Summary Report (OSR) dated 6/3/2024, the OSR indicated for licensed staff to administer Seroquel (antipsychotic drug) 100 milligram ([mg] unit of measurement) one tablet in the morning, and three tablets at bedtime by mouth, daily for paranoid schizophrenia to Resident 8, as manifested by hearing voices telling Resident 8 to hurt himself and others. During a review of Resident 8's Medication Administration Record (MAR) dated 6/3/2024 through 6/10/2024, the MAR indicated Resident 8 received Seroquel 100 mg one tablet at 9 a.m., and three tablets at 10 p.m. by mouth every day from 6/3/2024 through 6/10/2024. During a concurrent observation and interview on 6/4/2024 at 10:58 am, Resident 8 stated he just came back from a smoke break in the patio. Resident 8 stated he smoked in the patio by himself without staff supervision. Resident 8 had one opened pack of cigarette with 17 cigarettes, three disposable lighters on Resident 8's bedside table, and three unopened packs of cigarettes in Resident 8's cabinet drawer. Resident 8 demonstrated the three cigarette lighters were working (lighting up). Resident 8 stated he was a smoker and consumed 20 cigarettes per day (one pack of cigarette per day). Resident 8 stated staff (unable to recall the name) gave him the cigarettes and lighters (unable to recall the date) so he could smoke anytime without asking for the cigarettes and lighters from staff. Resident 8 stated he had been smoking without staff supervision (did not indicate timeframe). During a concurrent observation and interview with the DON in Resident 8's room on 6/4/2024 at 11:02 am, the DON stated she did not know why Resident 8 had four packs of cigarettes (one opened and three unopened) with three disposables lighters in Resident 8's room. The DON stated Resident 8 had not been evaluated for safe smoking and had no plan of care (CP) to address smoking when she checked Resident 8's medical record at around 10 am this morning (6/4/2024). The DON stated Resident 8 should not be in possession of cigarettes and lighters because it was an accident hazard. The DON stated the lighter could cause burns (damage to the skin caused by fire) to Resident 8 or cause fire in the facility. The DON stated Resident 8 could not smoke without staff supervision due to Resident 8's behavior of hearing voices telling him to hurt himself and others in the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview with the Social Services Director (SSD), and concurrent review of Resident 8's SE form, dated 6/4/2024, on 6/4/2024 at 2 pm, Resident 8's SE form indicated Resident 8 was not safe to have cigarette lighter in Resident 8's room and Resident 8 needed to be supervised by staff during smoke break. The SSD stated she was responsible for evaluation for all smokers, including Resident 8 in the facility. The SSD stated Resident 8 should not have cigarettes and lighter in Resident 8's possession and should be supervised by staff when smoking. The SSD stated she has not completed the SE for Resident 8 until this morning (6/4/2024) around 11:43 am after she was informed by the DON that Resident 8 had cigarettes and lighters in his possession in his room 48905 b. During a review of Resident 36's AR, the AR indicated the facility admitted Resident 36 on 3/18/2023 with diagnoses that included nicotine dependence and depression (persistent feelings of sadness and worthlessness and a lack of desire to engage in formerly pleasurable activities). During a review of Resident 36's untitled CP, dated 3/31/2023, the CP indicated Resident 36 had impaired visual function (poor vision) related to aging process. The CP interventions included for staff to alert Resident 36 to changes in the environment. During a review of Resident 36's untitled CP dated 2/27/2024, the CP indicated Resident 36 was at risk for a smoking related injury due to noncompliant behavior with smoking hours and designated areas. The CP goal was for Resident 36 to smoke with staff supervision. The CP interventions included for staff to accompany Resident 36 to smoke in the designated area, observe the resident during smoking hours, set limits with noncompliant behavior, and to monitor Resident 36 in safe handling and disposing of cigarette butts and ashes. During a review of Resident 36's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 3/25/2024, the MDS indicated Resident 36 had intact cognition (ability to understand). The MDS indicated Resident 36 used a walker and wheelchair for ambulation (walking/moving) and required supervision with walking for 10 feet (ft, unit of measurement). The MDS indicated Resident 36 required partial/moderate assistance (helper does less than half of the effort) for oral hygiene, toileting, and personal hygiene. During a review of Resident 36's SE form, dated 3/27/2024 at 9:27 am, the SE form indicated Resident 36 had poor vision and required supervision when smoking. During a review of Resident 36's History and Physical (H&P, formal document of a medical provider's examination of a patient) dated 4/10/2024, the H&P indicated Resident 36 had the capacity to understand and make decisions. During a review of Resident 36's untitled CP dated 5/25/2024, the CP indicated Resident 36 was a smoker. The CP goal indicated for Resident 36 not to smoke without supervision. The CP interventions included for staff to educate Resident 36 on proper disposal of cigarettes after smoking, explain the purpose of supervision for safety, and instruct Resident 36 that cigarettes and lighters were not allowed in Resident 36's possession. During an interview on 6/4/2024 at 10:46 am with the Assistant Administrator (AADM), the AADM stated there were no designated smoking times because all residents who smoke were alert and oriented. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a concurrent observation and interview on 6/4/2024 at 11:01 am with Resident 36 in the patio, Resident 36 was sitting in a chair, alone and unsupervised, next to a sliding glass door that was connected to Resident 36's room. Resident 36 placed a black cigarette pack into the basket of the front wheeled walker (FWW, an assistive device with four legs and two wheels on the front two legs) that was in front of Resident 36. Resident 36 stated Resident 36 just finished smoking in the patio and stated Resident 36 kept the cigarettes and lighters in Resident 36's possession for over a year. Resident 36 stated staff never supervised Resident 36 when Resident 36 smoked. Resident 36 stated Resident 36 had extra cigarette lighters in Resident 36's room in a tin container. Resident 36 stated Resident 36's roommate had an oxygen machine in Resident 36's room. Resident 36 stated Resident 36 was legally blind (the vision was less than 20 degrees which means if an object was 200 feet away, the resident/patient had to stand 20 feet from it in order to see it clearly). Resident 36 stated Resident 36 had difficulty using the ashtrays in the patio. Resident 36 stated Resident 36 placed cigarette butts inside a plastic bottle and threw the bottle in the trash can in the resident's bedroom when Resident 36 filled the bottle with cigarette butts. During a concurrent observation and interview on 6/4/2024 at 11:15 am with Registered Nurse Supervisor 1 (RN Sup 1) in Resident 36's room, an oxygen machine was next to Resident 36's roommate bed. A sign was posted outside Resident 36's door with red text that indicated Danger, Oxygen, No Smoking, No Open Flame. RN Sup 1 stated there was an oxygen machine in Resident 36's room and a Danger Sign was posted outside Resident 36's room. RN Sup 1 stated Resident 36 would smoke alone, outside in the patio in front of Resident 36's room. RN Sup 1 stated RN Sup 1 was unsure if Resident 36 could keep cigarettes and cigarette lighters at Resident 36's bedside. RN sup 1 stated RN sup 1 was unaware if Resident 36 could smoke unsupervised. During a concurrent interview and record review on 6/4/2024 at 11:16 am with RN Sup 1, Resident 36's untitled CP, dated 5/25/2024 was reviewed. The CP indicated Resident 36 required supervision during smoking and staff to instruct and educate Resident 36 that cigarettes and lighters were not allowed in Resident 36's possession. RN Sup 1 stated it was a fire hazard having a lighter at Resident 36's bedside or in Resident 36's possession because Resident 36's roommate had an oxygen machine in the room. RN Sup 1 stated Resident 36 needed supervision during smoking according to Resident 36's CP. RN Sup 1 stated Resident 36 needed to use the ashtray that was provided in the patio because the plastic bottle could catch fire when the cigarette butt was not extinguished (put out) completely. During a concurrent observation and interview on 6/4/2024 on 11:36 am with CNA 4 in Resident 36's room, there were seven disposable lighters, one unopened cigarette pack (20 cigarettes/pack) and one opened cigarette pack with two and half cigarettes in the box. CNA 4 stated all seven disposable lighters were functional. CNA 4 stated CNA 4 was unsure when Resident 36 got the seven lighters and kept them in Resident 36's room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 6/4/2024 at 4:56 pm with the DON, the DON stated cigarette lighters should not be at Resident 36's bedside especially when there was an oxygen machine in Resident 36's room because it could cause an explosion or fire. The DON stated staff needed to remove the lighters immediately from Resident 36 for Resident 36 and other residents' (other residents in the facility) safety. The DON stated Resident 36 needed supervision during smoking according to Resident 36's CP and SE form. The DON stated Resident 36's safety would be at risk when staff did not provide supervision during smoking. The DON stated residents who smoke (smokers in general) needed to use the ashtrays to dispose cigarette butts appropriately. The DON stated cigarette butts should not be placed inside of a used plastic bottle because it could cause fire when cigarette butts were not extinguished completely. During a review of the facility's undated Policy and Procedure (P&P) titled, Smoking Policy-Residents, the P&P indicated Residents without independent smoking privileges may not have or keep any smoking articles, including cigarettes, tobacco, etc. The P&P indicated Ashtrays are emptied into designated receptacles and the use of oxygen is prohibited in smoking areas. The P&P indicated Residents who smoked (smokers) needed to be evaluated on admission to determine if the residents had the ability to smoke safety with or without supervision. The P&P indicated Any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor, or volunteer worker at all times while smoking. The P&P further indicated Staff should consult with the attending physician and DON to determine if safety restrictions was needed on the residents' smoking privileges based on Safe Smoking Evaluation.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to provide necessary care and services for a resident with foley catheter (FC, thin, sterile tube inserted into the bladder to drain urine into a bag outside the body) as indicated in the resident's plan of care for one of two sampled residents (Resident 189). This failure had the potential to result in catheter-related complications for Resident 189. Findings: During a review of Resident 189's Admission Records (AR), the AR indicated Resident 189 was admitted to the facility on [DATE] with diagnoses that included urinary tract infection (UTI, an illness in any part of the urinary tract, the system of organs that makes urine) and benign prostatic hyperplasia (BPH, prostate gland enlargement that can cause urination difficulty). During a review of Resident 189's Minimum Data Set (MDS) dated [DATE], the MDS indicated Resident 189 had intact cognition. Resident 189 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) with toileting, shower, upper and lower body dressing. During a review of Resident 189's untitled Care Plan (CP), dated 6/1/2024, the CP indicated Resident 189 was at risk for infection due to the presence of a foley catheter. The CP interventions included to position to promote optimum drainage, tape the FC to inside of the thigh securing bag to the side of the bed , below the level of bladder for proper drainage. During an observation on 6/4/2024 at 9:26 am inside Resident 189's room, Resident 189 had a FC hanging on the left side of Resident 189's bed. Resident 189's FC was not secured or taped on the resident's inside of the thigh, as indicated in the CP. During an interview on 6/4/2024 at 9:30 am with Registered Nurse Supervisor 1 (RN Sup 1), RN Sup 1 stated, Resident 189's FC needed to be secured to prevent accidental pulling causing trauma to the resident. During an interview on 6/4/2024 at 10:46 am with RN Sup 3, RN sup 3 stated, Resident 189's FC should be anchored with a secured device to prevent pulling or dislodgement during peri-care (washing of genitals and anal area) causing tear or trauma to the urethra (tube through which urine leaves the body)/ urinary bladder (body organ that hold urine). During a review of the facility's undated policy and procedure (P&P) titled, Catheter Care, Urinary, the P&P indicated, Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site (Note: Catheter tubing should be strapped to the resident's inner thigh).

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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** 40438 Based on observation, interview and record review, the facility failed to accurately monitor the resident's fluid intake (measurement of the fluids that enter the body) for one of one sampled resident (Resident 30) as ordered by the physician. This failure had the potential for complications related to electrolyte imbalance for Resident 30. Findings: During a review of Resident 30's Admission Records (AR), the AR indicated Resident 30 was admitted to the facility on [DATE] with diagnoses that included hypertension (high blood pressure), anemia (a condition that occurs when the body doesn't have enough red blood cells to carry oxygen to the body's tissues) and atrial fibrillation (irregular, often rapid heart rate that commonly causes poor blood flow). During a review of Resident 30's untitled Care Plan (CP), dated 8/5/2021, the CP indicated Resident 30 had hypertension. The CP interventions included for staff to implement diet restrictions as ordered, monitor for compliance, monitor laboratory work and notify medical doctor (MD) for abnormal laboratory values. During a review of Resident 30's Order Summary Report (OSR), dated 9/2/2022, the OSR indicated Resident 30 had an order for fluid restriction (FR, limits the amount of fluids a person consumes each day) of 1200 cubic centimeter/24 hours (cc/24 hr., measure of volume per day) allotting 720 cc for dietary and 480 cc for nursing in which 200 cc was allotted for breakfast, 200 cc for lunch and 80 cc for dinner. During a review of Resident 30's untitled CP, dated 9/23/2022, the CP indicated Resident 30 had hyponatremia (a condition where the level of sodium was lower than normal). The CP interventions included for staff to implement fluid restrictions 1200 cc/24 hours, document fluid intake, explain the importance of adhering to FR and monitor laboratory as ordered. During a review of Resident 30's Sodium (Na) Level result, dated 2/6/2024, Resident 30's Na level was 132 milliequivalents per liter (mEq/L, unit of measurement). Normal Na range was 135-145 mEq/L. During a review of Resident 30's Na Level result dated 5/1/2024, Resident 30's Na level was 128 mEq. During a review of Resident 30's Minimum Data Sheet (MDS, a standardized assessment and care planning tool), dated 5/1/2024, the MDS indicated, Resident 30 had an intact cognition (ability to understand) and required moderate assistance (helper does less than half the effort) with toileting, shower, upper and lower body dressing. During a review of the Resident 30's Fluid Restriction Monitoring (FRM) for Nursing and Fluid Intake (FI) for Dietary, the following were documented: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	FRM (Nursing-480 cc) FI (Dietary-720 cc) 6/1/2024 480 cc 760 cc 6/2/2024 1000 cc 885 cc 6/3/2024 1000 cc 1160 cc 6/4/2024 880 cc 1550 cc During an observation on 6/4/2024 at 10:34 am inside Resident 30's room, Resident 30 did not have a water pitcher or cups on the table. Resident 30 had one case of 50 milliliters (ml, a measure of volume) of water bottles on the floor. During a review of Resident 30's Na Level result, dated 6/5/2024, Resident 30's Na level was 132 mEq. During an interview on 6/5/2024 at 11:34 am with Certified Nurse Assistant 6 (CNA 6), CNA 6 stated she did not know any resident on fluid restriction in the facility. CNA 6 stated the fluid the resident consumed from their meal tray were documented under Dietary. During an interview on 6/5/2024 at 11:40 am with Licensed Vocation Nurse 4 (LVN 4), LVN 4 stated, she asked Resident 30 how much he drank from the water bottle. One water bottle was 480 to 500 ml. LVN 4 stated the amount of fluid intake was estimated. LVN 4 stated LVN 4 did not use a measuring cup to measure fluid intake for Resident 30. During an interview on 6/5/2024 at 12:49 pm with CNA 6, CNA 6 stated CNA 6 measured fluid intake from what the resident took/had from their tray. CNA 6 stated a regular cup contained 160 ml and a small cup had 120 ml. CNA 6 stated he did not know how to measure if a resident drink from the water bottle. During an interview on 6/5/2024 at 1:55 pm with LVN 5, LVN 5 stated, residents (in general) on fluid restriction were communicated to the kitchen staff and to the CNAs. LVN 5 stated adhering to the fluid restriction was important to prevent complications. During an interview on 6/5/2024 at 2:34 pm with the facility's Director of Nursing (DON), the DON stated, low sodium level was not good because it would cause health and medical complications. During a review of the facility's undated policy and procedure (P&P) titled, Fluid Restriction, the P&P indicated, Dietary and nursing staff will coordinate, so that both departments concur on the amount of fluid distribution they are allowed to give the resident daily. The resident's fluid intake and output will be recorded by a licensed nurse in the MAR. Licensed nursing staff on the 11:00 pm - 7:00 am shift will be responsible for recording and documenting the resident's total daily intake and output.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to provide necessary care and services for gastrostomy tube (GT, a tube inserted through the abdomen that delivers nutrition directly to the stomach) tubing and site as ordered by the physician and as indicated in the plan of care for two of three sampled residents (Residents 193 and 195). These failures had the potential for infection and adverse consequences related to tube feedings for Residents 193 and 195. Findings: a. During a review of Resident 193's Admission Records (AR), the AR indicated Resident 193 was admitted to the facility on [DATE] with diagnoses that included subdural hemorrhage (a pool of blood between the brain and its outermost covering) and epilepsy (a seizure disorder) During a review of Resident 193's untitled Care Plan (CP), dated 5/1/2024, the CP indicated Resident 193 had a feeding tube related to dysphagia (difficulty swallowing). The CP goal was for Resident 193 to tolerate tube feeding without complications. During a review of Resident 193's Minimum Data Sheet (MDS, a standardized assessment and care planning tool), dated 5/8/2024, the MDS indicated, Resident 193 had an intact cognition (ability to understand) and required moderate assistance (helper does less than half the effort) with shower, upper and lower body dressing. The MDS indicated Resident 193 was on tube feeding for nutrition. During a concurrent observation and interview on 6/4/2024 at 10:07 am with Licensed Vocational Nurse 2(LVN 2) inside Resident 193's room, Resident 193 had a GT tubing with the end of the tubing open and left hanging on the pole. LVN 2 stated the end of the tubing needed to be covered with a cap to maintain the quality of the feeding formula and for infection control. During an interview on 6/4/2024 at 10:46 am with Registered Nurse Supervisor 3 (RN Sup 3), RN Sup 3 stated, the end tubing of the GT should not be left open to air to prevent infection. During an interview on 6/7/2024 at 11:49 am with the Director of Nursing (DON), the DON stated, the end of the GT should be covered with a cap when disconnected from the resident to prevent spoilage and contamination of the feeding formula and to prevent infection. b. During a review of Resident 195's AR, the AR indicated Resident 195 was admitted to the facility on [DATE] with diagnoses that included senile degeneration of the brain (mental decline associated with aging) and altered mental status (change in mental function). During a review of Resident 195's untitled CP, dated 6/3/2024, the CP indicated Resident 195 had a feeding tube related to dysphagia. The CP goal was for Resident 195 to tolerate tube feedings without complications. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 195's Order Summary Report (OSR) dated 6/3/2024, the OSR indicated for licensed staff to clean Resident 195's GT site with normal saline (NS), pat dry, and apply dry dressing daily every day shift. During a concurrent observation and interview on 6/4/2024 at 10:23 am with LVN 2, Resident 195's GT site did not have a cover or dressing. LVN 2 stated Resident 195's GT site needed to be covered to prevent infection and to prevent pulling when performing care and/or during turning/repositioning the resident. During an interview on 6/6/2024 at 8:39 am with the Infection Preventionist Nurse (IPN - a nurse who helps prevent and identify the spread of infectious disease in the healthcare environment), IPN stated, Resident 195's GT site should be covered as ordered. IPN stated the cover served to absorb any leakage from the site to prevent skin irritation and infection. During an interview on 6/7/2024 at 11:49 am with the Director of Nursing (DON), the DON stated, GT site should be covered as ordered by the physician to protect the skin from irritation and to prevent accidental pulling during movement. During a review of the facility's undated policy and procedure (P&P) titled, Enteral Feedings - Safety Precautions, the P&P indicated, When formula is not in use, a licensed nurse will ensure that the resident's enteral tube is securely capped and closed. Preventing skin breakdown - apply new dressing per physician order, label the dressing with the date & time it was applied, coil the tubing off to the side of the enteral feeding site and tape to the resident's body to prevent tagging and kinks or knots in the tube.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to provide necessary care and services for residents on oxygen therapy (a treatment that provides with extra oxygen to breathe in) as ordered by the physician, as indicated in the residents' plan of care and in accordance with the facility's Policy and Procedure (P&P) on Oxygen Administration for four of seven sampled residents (Residents 2, 31, 64 and 189). These failures had the potential to result in respiratory complications and infection for Residents 2, 31, 64 and 189. Findings: a. During a review of Resident 189's Admission Record (AR), the AR indicated the facility admitted Resident 189 on 4/7/2024 with diagnoses that included hypertension (high blood pressure), morbid obesity (a disorder that involves having too much body fat) and atherosclerosis of the aorta (a condition that occurs when plaque builds up on the inner walls of the aorta). During a review of Resident 189's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 4/17/2024, the MDS indicated Resident 189 had intact cognition (ability to understand). The MDS indicated Resident 189 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) with toileting, shower and upper and lower body dressing. During a review of Resident 189's Order Recap Report (ORR), dated 6/3/2024, the ORR indicated Resident 189 had an order for continuous oxygen at 2 liters/nasal cannula (L/NC, amount of oxygen delivered by nasal cannula) for shortness of breath. During a review of Resident 189's untitled Care Plan (CP), dated 6/6/2024, the CP indicated Resident 189 was on oxygen therapy related to shortness of breath due to morbid obesity. During an observation on 6/4/2024 at 9:26 am inside Resident 189's room, Resident 189 had ongoing oxygen flowing at 2L/NC. The oxygen tubing did not have a label with the date when it was changed or started. b. During a review of Resident 31's AR, the AR indicated the facility admitted Resident 31 on 2/21/2023 with diagnoses that included congestive heart failure (a condition in which the heart doesn't pump blood), respiratory failure (a serious condition that makes it difficult to breathe on your own) and pneumonia (infection that inflames air sacs in one or both lungs). During a review of Resident 31's MDS dated [DATE], the MDS indicated Resident 31 had moderately impaired cognition. The MDS indicated Resident 31 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) with shower and required moderate assistance (helper does less than half the effort) with toileting, upper and lower body dressing, and personal hygiene. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 31's Order Summary Report (OSR), dated 5/23/2024, the OSR indicated Resident 31 had an order for oxygen at 2 liters per minute/nasal cannula (L/NC), as needed for shortness of breath. During a review of Resident 31's untitled CP, revised on 5/7/2024, the CP indicated Resident 31 was on oxygen therapy related to chronic (persisting for a long time) respiratory failure. During an observation on 6/4/2024 at 10:40 am inside Resident 31's room, Resident 31 had ongoing oxygen at 2L/NC. Resident 31's oxygen tubing did not have a label with the date when it was changed or started. During an interview on 6/4/2024 at 10:46 am with Registered Nurse Supervisor 3 (RN Sup 3), RN Sup 3 stated, Resident 31's tubing needed to be have a label with the date it was changed to know that oxygen tubing was changed on schedule and for infection control. During an interview on 6/6/2024 at 8:39 am with the facility's Infection Preventionist Nurse (IPN- a nurse who helps prevent and identify the spread of infectious disease in the healthcare environment), IPN stated, oxygen tubing needed to be changed regularly and labeled with the date it was changed to keep it clean and prevent infection. 48905 c. During a review of Resident 2's AR, the AR indicated the facility admitted Resident 2 on 7/30/2019 and readmitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD, disease that prevents lungs to fully expand causing restricted airflow). During a review of Resident 2's History and Physical (H&P, a formal document of a medical provider's examination of a patient) dated 12/30/2023, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's untitled CP dated 4/11/2024, the CP indicated Resident 2 had oxygen therapy as needed (PRN) for COPD. The CP indicated for staff to provide oxygen at two liters (L-unit of measurement) through a nasal canula (NC, device that delivers oxygen through a tube into the nose) PRN. During a review of Resident 2's OSR dated 4/11/2024, the OSR indicated Resident 2 had an active physician's order for staff to administer oxygen at two liters per minute through NC, PRN for shortness of breath (SOB). During a review of Resident 2's untitled CP dated 4/15/2024, the CP indicated Resident 2 was at risk for ineffective breathing related to COPD. The CP indicated for staff to administer oxygen at two L via NC as ordered. During a concurrent observation and interview on 6/4/2024 at 10:52 AM with Registered Nurse Supervisor 1 (RN Sup 1) in Resident 2's room, an oxygen concentrator machine (medical device used to deliver oxygen) was at Resident 2's bedside with the NC tubing coiled into a plastic bag. RN Sup 1 stated there was no date on the oxygen tubing to indicate when it was last changed. RN Sup 1 stated the risk of not labeling oxygen tubing was that bacteria can grow inside of the NC tubing. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/6/2024 at 8:36 AM with the IPN, the IPN stated the IPN was responsible for placing the date on the oxygen tubing and stated all oxygen tubing should be labeled with the date it was last changed. IPN stated if the oxygen tubing was not labeled, the resident would have an old oxygen tube with bacteria growth due to moisture accumulating in the tubing. During an interview on 6/10/2024 at 11:30 AM with the facility's' Director of Nursing (DON), the DON stated oxygen tubing needed to be replaced every Friday. The DON stated there was an assigned nurse to check if there was a date on the oxygen tubing. The DON stated oxygen tubing should be dated of when it was changed and the risk of not having a date on the oxygen tubing was that resident would be inhaling oxygen through a dirty and old tube. During a review of the facility's undated P&P titled, Oxygen Administration the P&P indicated the NC will be changed once a week on Fridays and nursing staff will be responsible for changing the resident's NC tubing and tubing's storage bag. The P&P indicated a label noting the date changed will be adhered to the tubing and the plastic storage bag. 14330 d. During a review of Resident 64's AR, the AR indicated the facility admitted Resident 64 on 7/27/2022, with diagnoses that included hypertensive chronic kidney disease (elevated blood pressure caused by kidney disease) and dependence on supplemental oxygen (long term oxygen therapy). During a review of Resident 64's OSR dated 4/1/2024, the OSR indicated an order for licensed staff to provide Resident 64 two liters (unit of measurement) of oxygen continuously through nasal cannula (a flexible soft tube that delivers extra oxygen through a tube and into the nose) for chronic respiratory failure (lungs cannot get enough oxygen into the blood). During an observation on 6/4/2024 at 9:25 a.m. and 9:50 a.m., Resident 64 was lying on her back in bed with ongoing oxygen inhalation at two liters per minute through nasal cannula. Resident 64 was asleep, and the nasal prongs (flexible soft two prongs that go inside the nostrils that deliver oxygen) was under Resident 64's chin. During a concurrent observation and interview on 6/4/2024 at 10:04 a.m., Resident 64 was awake in bed with ongoing oxygen at two liters per minute while the nasal prongs was under her chin. Resident 64 stated she fell asleep after eating breakfast and woke up with the nasal prongs under her chin. Resident 64 stated staff came to see her, but the nasal prongs was not placed back into her nostrils (two openings in the nose) for her to receive the necessary amount of oxygen she needed. The Registered Nurse Supervisor 1 (RNS 1) was present in Resident 64's room and RNS 1 observed the nasal prongs was under Resident 64' chin. RNS 1 stated RNS 1 did not check Resident 64 for proper placement of nasal prongs when RNS 1 made rounds at around 9 a.m. today (6/4/2024). RNS 1 stated nasal prongs needed to be properly positioned in Resident 64's nostrils for Resident 64 to receive adequate amount of oxygen to prevent shortness of breath, as ordered. During a review of the facility's undated P&P titled, Oxygen Administration, the P & P indicated nasal cannula should be placed approximately one-half inch in the resident's nose and the licensed nurse should monitor the placement of cannula at all times.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 14330 Based on observation, interview, and record review, the facility failed to ensure dialysis emergency kit was readily available for staff use in case of bleeding in resident's dialysis (a type of treatment that helps the body remove extra fluid and waste products from the blood when the kidneys are not able to) access site for two of two sampled residents on dialysis (Residents 44 and 85). This deficient practice placed Residents 44 and 85 at risk for excessive bleeding from dialysis access site. Findings: a. During a review of Resident 85's Admission Record (AR), the AR indicated the facility admitted Resident 85 on 4/6/2024, with diagnoses that included diabetes mellitus (a condition that happens when the blood sugar [glucose] is too high) and dependence on renal dialysis. During an observation on 6/4/2024 at 11:09 a.m., Resident 85 was lying on his back in bed, alert and coherent. Resident 85's left upper arm dialysis access site was intact. During a concurrent observation and interview with the Treatment Nurse (TN) in Resident 85's room on 6/4/2024 at 11:17 a.m., the TN stated she did not find the dialysis emergency kit of Resident 85 after looking at Resident 85's bedside table, drawer, and closet. The TN stated dialysis emergency kit should be readily available at Resident 85's bedside to immediately control the bleeding in the dialysis access site in an emergency, to prevent excessive blood loss that might result in serious harm and/or death of the resident. 40913 b. During a review of Resident 44's AR, the AR indicated the facility admitted Resident 44 on 8/7/2023, with diagnoses that included end stage renal disease (medical condition in which a person's kidneys cease functioning on a permanent basis) and dependence on renal dialysis. During a review of Resident 44's Minimum Data Set (MDS - a standardized assessment and care planning tool) dated 5/16/2024, the MDS indicated the resident had intact cognition. The MDS indicated Resident 44 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with bed mobility such as rolling left and right, sit to lying, lying to sitting on the side of the bed). During a concurrent observation and interview on 6/4/2024 at 8:46 am, there was no emergency dialysis kit at the bedside of Resident 44. Registered Nurse Supervisor 4(RN Sup 4) checked inside Resident 44's drawers and could not find the emergency dialysis kit or emergency dressing kit. During a concurrent observation and interview on 6/4/2024 at 8:55 am, RN Sup 4 stated the dialysis emergency kit would be used in cases of bleeding from the dialysis access site. RN Sup 4 stated it was important to have the emergency dialysis kit readily available to use in case of emergency. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/10/2024 at 4:19 pm with the Director of Nursing (DON), the DON stated the facility did not have policies and procedure to keep dialysis emergency kits at the bedside.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 14330 Based on observation, interview, and record review, the facility failed to post accurate nurse staffing information of actual hours worked by the licensed and unlicensed nursing staff directly responsible for resident care per shift daily. The staffing information was not posted in a prominent location for two of four days during the recertification survey. This deficient practice had the potential to mislead the residents and visitors of the actual hours worked by licensed and unlicensed nursing staff directly providing resident care and had the potential to affect the quality of nursing care provided to the residents. Findings: During a concurrent observation and interview on 6/4/2024 at 9:30 a.m. and 6/5/2024 at 9 a.m., the facility's staffing information was posted inside the North Nurses' Station and no staffing information was posted in the South Nurse's Station of the facility. The staffing information indicated actual hours worked by the nursing staff on all shifts (7 am-3 pm, 3pm-11 pm and 11 pm-7 am). During a concurrent interview and review on 6/5/2024 at 10 a.m., the Director of Staff Development (DSD) stated staffing information was projected actual hours worked by nursing staff on all shifts. The DSD stated she was not aware staffing information needed to be posted in a prominent location that should be accessible for review by the residents, family, and visitors to determine if the facility had enough staff to take care of the residents. The DSD stated staffing information posted inside the North Nurses' Station was not accessible for residents, family, and visitors because they are not allowed to enter the nurses' station. DSD stated she was responsible for the nurse staffing information completion and posting at the beginning of each shift, daily. During a review of the facility's undated Policy and Procedures (P&P) titled, Posting Direct Care Daily Staffing Numbers, the P&P indicated staffing information should count only the total number of hours the staff was scheduled to work for the shift being posted and should be posted in a prominent location by the Supervisor within two hours of the beginning of each shift.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40913 Based on observation, interview, and record review, Licensed Vocational Nurse 2 (LVN 2) failed to ensure enteric coated (barrier to prevent gastric acids in the stomach from dissolving or degrading medications after being swallowed) Aspirin (medication to prevent blood clot) was not crushed for one of four sampled residents (Resident 7) during medication administration. This deficient practice had the potential to affect Resident 7's medication efficacy and placed the resident at risk for adverse complications. Findings: During a review of Resident 7's Admission Record (AR), the AR indicated the facility admitted the resident on 5/2/2016 and readmitted on [DATE] with diagnoses that included gastroesophageal reflux disease with esophagitis (a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach) dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning) and atherosclerotic heart disease (condition where the arteries become narrowed and hardened due to a buildup of plaque around the artery wall). During a review of Resident 7's Minimum Data Set (MDS - a standardized assessment and care planning tool) dated 2/27/2024, the MDS indicated the resident sometimes understands verbal content and rarely/never able to express ideas and wants. The MDS indicated Resident 7 was dependent with all activities of daily living. During a medication administration observation on 6/6/2024 from 8:23 am to 8:31 am, LVN 2 prepared a total of 8 scheduled medications for Resident 7, including Aspirin. LVN 2 crushed the medications and mixed with apple sauce. LVN 2 administered all the medications mixed in apple sauce. During a concurrent interview and observation on 6/6/2024 at 8:43 am, LVN 2 stated she would always crush Resident 7's medications because Resident 7 could not swallow the medications in whole. LVN 2 checked Resident 7's medication bottle for Aspirin and the bottle indicated enteric coated Aspirin 81 milligrams (mg-unit of measurement.) LVN 2 stated she did not know if she could crush enteric coated Aspirin. During an interview on 6/10/2024 at 4:35 pm, the Director of Nursing (DON) stated delayed release/enteric coated medications should not be crushed and the facility needed to call the physician for an alternative medication and a physician's order to crush medications. The DON stated the alternative form of oral enteric coated Aspirin could be in a liquid form or sublingual form (applied under the tongue) During a review of Resident 7's active Physician Orders as of 6/2/2024, the physician's order indicated for Resident 7 to receive Aspirin EC (enteric coated) tablet delayed release, one tablet by mouth one time a day for prophylaxis. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's undated Policy and Procedure (P&P) titled The Med Pass, the P&P indicated a list of medications not to be crushed should be available for reference in the Medication Administration Record. During a review of the facility's undated P&P titled Physician Medication Orders, indicated medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications.

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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** 14330 Based on observation, interview and record review, the facility failed to ensure five of five sampled residents (Residents 13, 25, 41, 47 and 77) on psychotropic drugs (any drug capable of affecting the mood, emotions, and behavior) were free from unnecessary medication by failing to: A. Attempt a Gradual Dose Reduction (GDR- tapering of a dose) for Residents 25 and 47 B. Ensure PRN (as needed) orders for psychotropic medications were limited to 14 days use for Residents 13, 41, and Resident 77. These deficient practices had the potential for the facility to use psychotropic drugs inappropriately and had the potential to affect residents' physical, emotional and psychosocial wellbeing. Findings: A.1. During a review of Resident 25's Admission Record (AR), the AR indicated the facility admitted Resident 25 on 4/28/2023, under Hospice Care (a program that gives special care to people who are near the end of life and have stopped treatment to cure or control their disease) due to diagnosis of end stage Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). During an observation on 6/4/2024 at 10:47 a.m., Resident 25 was lying on his back in a low bed, awake and non-communicative. During a review of Resident 25's Order Summary Report (OSR), the physician orders indicated the following: 1. Seroquel (antipsychotic [medication to treat mental illness] medication) 25 milligrams (mg-unit of measurement) one tablet in the morning and 50 mg one tablet at bedtime, by mouth for agitation related to dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning); order date was 4/28/2023 2. Haloperidol Lactate oral concentrate 2mg/ml (antipsychotic medication) 2 mg sublingual (under the tongue) every six hours as needed (PRN) for agitation related to dementia; order date was 4/10/2024. During a review of Resident 25's Medication Administration Record (MAR) dated 6/1/2024 through 6/7/2024, the MAR indicated Resident 25 received Seroquel 25 mg one tablet at 9 a.m. and 50 mg one tablet at 10 p. m. by mouth, every day. During a review of Resident 25's monthly behavior monitoring of agitation due to dementia dated 4/28/2023 through 6/7/2024, the monthly behavior monitoring indicated Resident 25 had only two episodes of agitation since Seroquel and Haldol PRN were ordered for Resident 25. (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 with the Director of Nursing (DON) on 6/7/2024 at 4:32 p.m., the DON stated she was responsible for checking residents on psychotropic medication had gradual dose reduction (GDR- tapering of medication) unless clinically contraindicated. The DON stated, Resident 25's antipsychotic drug (Seroquel) was ordered by the Hospice physician upon admission to the facility on [DATE]. The DON stated she notified the Hospice Registered Nurse (HRN) by phone about a month ago to discontinue Resident 25's Seroquel and Haldol due to absence of behavior problem of agitation but the DON stated she missed to follow up if the order was obtained. The DON stated Resident 25's medical record did not have documented evidence of a failed past or recent attempt of GDR for Seroquel to medically justify it would be clinically contraindicated for Resident 25. The DON stated there was no documented evidence Resident 25's physician made an evaluation for the appropriateness of the use of Haldol beyond 14 days. The DON stated antipsychotic PRN drug should not exceed 14 days, but it was overlooked. The DON stated GDR was necessary to determine if Resident 25's agitation would be managed by a lower dose with the use of non-drug interventions to prevent adverse drug reactions. A.2. During a review of Resident 47's AR, the AR indicated the facility admitted the resident on 12/18/2020, with diagnoses that included Alzheimer's disease (irreversible, progressive brain disorder that slowly destroys memory and thinking skills, and eventually the ability to carry out the simplest tasks) and dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning.) During a review of Resident 47's Minimum Data Set (a standardized assessment and care planning tool) dated 3/24/2024, the MDS indicated the resident had severe cognitive impairment and had no symptoms for problems with mood. The MDS indicated Resident 47 was dependent with toileting and required maximal assistance with eating, bed mobility. During a review of Resident 47's OSR, the OSR indicated the following order history for the use of Seroquel for Resident 47: On 3/30/21, Seroquel 50 milligrams (mg.-unit of measurement) at bedtime and Seroquel 25 mg. once a day, was ordered. On 5/28/21, Seroquel 50 mg. at bedtime and 25 mg. once a day, was ordered. On 6/30/21, Seroquel 50 mg. at bedtime and 25 mg. once a day, was ordered. On 8/4/21, Seroquel 50 mg. two times a day, was ordered. On 11/10/21, Seroquel 50 mg. two times a day, was ordered. On 7/20/22, Seroquel 50 mg. at bedtime and 25 mg. once a day, was ordered. On 7/26/22, Seroquel 50 mg. at bedtime and 25 mg. once a day. was ordered. On 10/20/22, Seroquel 50 mg. at bedtime and 25 mg. once a day. was ordered. On 3/4/23, Seroquel 50 mg. at bedtime and 25 mg. once a day. was ordered. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/7/23, Seroquel 50 mg. at bedtime and 25 mg. once a day. was ordered. Seroquel 50 mg at bedtime and 25 mg. once a day had been ordered since 7/20/2022 and was reordered for the same dose on 7/26/22, 10/20/22, 3/4/23 and 10/7/23. During multiple observations on 6/4/2024 at 12:16 pm and on 6/5/2024 at 8:35 am and at 11:16 am, Resident 47 was quietly watching TV while in bed. During a concurrent record review and interview with Registered Nurse Supervisor 2 (RN Sup 2) on 6/7/2024 at 5:55 pm, Resident 47's behavior monitoring on the following dates were as follows: - On 9/2023, there was zero episodes of hallucinations and one episode of Resident 47 talking to people not present. - On 10/2023 there was one episode on 10/18/2023, 10/25/2023, 10/26/2023 of Resident 47 talking to others not there and two episodes on 10/9/23 of Resident 47 talking to others not present. RN Sup 2 stated there was no record of GDR for the use of Seroquel on Resident 47. RN Sup 2 stated Seroquel dose was re-ordered on 10/7/2023. RN Sup 2 stated the behavior monitoring did not indicate several behavior incidents for Resident 47. RN Sup 2 stated at the time the dose was reordered on 10/7/23, Resident 47 was getting more active and trying to get out of bed. During a review of the facility's undated Policy and Procedure (P&P) titled Tapering Medications and Gradual Dose Reduction indicated within the first after a resident is admitted on an antipsychotic medication or after the resident has been started on an antipsychotic medication, the staff and practitioner shall attempt a GDR in two separate quarters (with at least one month between the attempts,) unless clinically contraindicated. After the first year, the facility shall attempt a GDR at least annually, unless clinically contraindicated. 48905 B.1. During a review of Resident 13's AR, the AR indicated the facility admitted Resident 13 on 7/1/2023 and readmitted on [DATE] with diagnoses that included anxiety (emotion characterized by an unpleasant state of inner turmoil and fear) and depression (persistent feelings of sadness and worthlessness and a lack of desire to engage in formerly pleasurable activities). During a review of Resident 13's untitled care plan (CP), dated 12/11/2023, the CP indicated Resident 13 was on antianxiety medication for anxiety manifested by self-reports of feeling anxious. The CP indicated for staff to administer Ativan (medication used to treat anxiety) 0.5 milligram (mg, a unit of measurement) orally (by mouth) every eight hours as needed (PRN) on 12/11/2023. During a review of Resident 13's MDS dated [DATE], the MDS indicated Resident 13's cognitive abilities (ability to think, learn, and process information) were intact. During a review of Resident 13's OSR dated 6/7/2024, the OSR indicated Resident 13 had a physician's order for Ativan oral tablet 0.5 milligram for anxiety manifested by restlessness and panic attacks every eight hours, PRN. (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 review of Resident 13's MAR dated 5/2024 to 6/2024, the MAR indicated Resident 13 received Ativan 0.5 mg daily from 5/22/2024 to 6/6/2024. During an interview on 6/7/2024 at 10:39 AM with the Minimum Data Set Nurse (MDS Nurse), the MDS Nurse stated PRN antipsychotics are to be ordered for only 14 days and then reevaluated by the physician. The MDS Nurse stated the physician needed to put a stop order after 14 days, evaluate the resident, and provide a new order. The MDS nurse stated the order for Ativan for Resident 13 should have been discontinued and stated the risk of continuing a PRN antipsychotic medication past 14 days was that the resident would receive unnecessary medication. During an interview on 6/10/2024 at 11:23 AM with the Director of Nursing (DON), the DON stated PRN antipsychotics should only be used for 14 days in accordance with regulations. The DON stated Resident 13's PRN order for Ativan should have been discontinued and reevaluated by the physician for appropriateness of continued use. The DON stated the risk of not stopping the medication was the resident would have a decline in function due to the side effects of the medication. During a review of the facility's undated P&P titled, Antipsychotic Medication Use the P&P indicated PRN orders for antipsychotic mediations will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of the medication. 40913 B.2. During a review of Resident 41's AR, the AR indicated the facility admitted the resident on 6/21/2019 and readmitted on [DATE], with diagnoses that included Alzheimer's' disease and dementia. During a review of Resident 41's MDS dated [DATE], the MDS indicated the resident had severe cognitive impairment and had zero symptoms for mood problems. The MDS indicated the resident was dependent with eating and toilet hygiene and required maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) with bed mobility. During a review of Resident 41's recapped Physician Orders, the physician's orders indicated for Resident 41 to receive alprazolam 0.25 mg. for more than 14 days as ordered: On 8/18/2022, alprazolam tablet 0.25 mg, 1 tablet by mouth every 8 hours PRN for agitation/yelling out was ordered. On 4/3/2023, alprazolam tablet 0.25 mg, 1 tablet by mouth every 8 hours PRN for anxiety as manifested by verbalization of nervousness leading to agitation was ordered. On 5/21/2024, alprazolam tablet 0.25 mg, 1 tablet by mouth every 8 hours PRN for anxiety as manifested by verbalization of nervousness leading to agitation was ordered. During a concurrent record review and interview on 6/7/2024 at 3:53 pm, Registered Nurse Supervisor 3 (RN Sup 3) stated PRN orders for alprazolam for Resident 41 needed a duration of 14 days only and the physician needed to assess or evaluate the need for the continued use of alprazolam for Resident 41. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B.3. During a review of Resident 77's AR, the AR indicated the facility admitted the resident on 4/22/2024 with diagnoses that included dementia and anxiety disorder (group of mental disorders characterized by feelings of anxiety [an unpleasant state of inner turmoil] and fear.) During a review of Resident 77's MDS dated [DATE], the MDS indicated the resident had severe cognitive impairment and had zero symptoms for problems or behaviors related to mood. The MDS indicated Resident 77 was dependent with toileting and required maximal assistance with bed mobility. During a review of Resident 77's recapped Physician Orders, the physician's orders indicated for Resident 77 to receive Ativan oral tablet 0.5 mg., 1 tablet by mouth every 2 hours as needed for anxiety manifested by agitation, ordered since 5/6/2024. During an interview on 6/10/24 at 8:21 am with the DON, the DON stated Ativan order for Resident 77 needed to be ordered for a duration of 14 days only and the physician needed to reevaluate the resident every time the Ativan order was renewed for Resident 77.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on observation, interview, and record review, the facility failed to follow its policy and procedure (P&P) on Storage of Medications to ensure drugs and biologicals (class of medicines which were grown and purified) were stored in the Medication Refrigerator (MR) at required temperature for one of one sampled Medication Storage room [ROOM NUMBER] (MSR 1). This failure had the potential to result in medications to become unstable and ineffective. Findings: During a concurrent observation and interview on 6/7/2024 at 9:27 AM with Licensed Vocational Nurse 4 (LVN 4) in MSR 1, the MR thermometer inside MR indicated a temperature of 62 degrees Fahrenheit (F, unit to measure temperature). LVN 4 stated the temperature reading inside the MR was 62 degrees F. LVN 4 stated the thermometer was unsure if the thermometer was broken. LVN 4 stated the temperature in the MR was rechecked and indicated a temperature of 56 degrees F. LVN 4 stated the required MR temperature needed to be between 36 degrees F and 46 degrees F according to the facility's temperature log. LVN 4 stated having a broken thermometer in the MR had the potential to decrease the effectiveness or stability of the medications inside the MR. During an interview on 6/7/2024 at 4:56 PM with Registered Nurse Supervisor 2 (RN Sup 2), RN Sup 2 stated the MR temperature should be between 36 to 46 degrees F. The RN Sup 2 stated the risk of not maintaining the MR at the required temperature was that it can affect the potency of the medication and bacteria could grow. During a review of the facility's policy and procedure (P&P) titled, Storage of Medication the P&P indicated MR must contain working thermometers which licensed nurses use to log the temperature twice daily to ensure the temperature stays between 36 degrees F and 46 degrees F.

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety 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** 40438 Based on observation, interview, and record review, the facility failed to maintain safe food handling practices by failing to: A.1. Store one of one ice scoop in a sanitary condition. The ice scoop was stored in the ice scooper container that had approximately 100 milliliters (ml-unit of measurement) of brown liquid substance. The ice scoop was touching the brown liquid substance. Certified Nursing Assistant 1 (CNA 1) and CNA 3 used the contaminated ice scooper to fill up two ice chests (containers) with ice and distributed the ice chests to the North and South Nursing Stations. CNAs 1, 2 and 3 distributed the contaminated ice to 42 of 90 residents (Residents 1, 2, 3, 4, 5, 6, 8, 11, 12, 13, 16, 17, 18, 20, 22, 23, 25, 27, 29, 36, 37, 38, 43, 46, 53, 54, 57, 58, 63, 64, 68, 71, 75, 76, 80, 84, 188, 189, 190, 238, 290 and 291) who received ice in the facility during breakfast and lunch on [DATE]. A.2. Ensure one of one ice scooper container used to store the ice scooper was cleaned and sanitized daily in accordance with the facility's Policy and Procedure (P&P) titled, Cleaning and Sanitizing Ice Scooper and Container for Ice Machine. These deficient practices placed Residents 1, 2, 3, 4, 5, 6, 8,11,12,13,16,17,18, 20, 22, 23, 25, 27, 29, 36, 37, 38, 43, 46, 53, 54, 57, 58, 63, 64, 68, 71, 75, 76, 80, 84, 188, 189, 190, 238, 290 and 291 at risk for consuming contaminated ice and result in serious harm, hospitalization , and death from water-borne illnesses (illnesses caused by contaminated water). B.Ensure safe food storage in accordance with the facility's policy and procedure (P&P) on Sanitation and Infection Control and P&P on Food Receiving and Storage by failing to ensure (1) stored food items were dated when it was received in one of two kitchen freezers, (2) mixed and prepared salad dressings were discarded after its indicated shelf life (the length of time for which an item remains usable and fit for consumption) in the kitchen refrigerated storage, (3) stored food items were dated when it was received in the kitchen's dry and canned storage area and (4) stored food items were labeled with the resident's name and date when it was stored and use by date in one of two unit refrigerators. These deficient practices placed the residents at risk for food-borne illnesses (illness caused by ingesting contaminated food or beverages). (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 5:34 pm, while onsite at the facility, the survey team called an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) situation regarding the facility's failure to ensure food safety standards were met by storing the food equipment in a sanitary condition. The ice scoop was stored in the ice scooper container that had approximately 100 ml of brown liquid substance which was used by CNAs 1 and 3 to scoop the ice from the ice machine intended for the residents in the facility. CNAs 1, 2 and 3 distributed the contaminated ice to 42 residents during breakfast and lunch on [DATE]. The facility had no records of cleaning and sanitizing the ice scooper container as indicated in the facility's P&P for Cleaning and Sanitizing Ice Scooper and Container for Ice Machine. The IJ was called in the presence of the facility's Director of Nursing (DON) and Director of Staff Development (DSD). On [DATE] at 3:42 pm, the facility submitted an acceptable IJ Removal Plan ([IJRP] a plan with interventions to correct the deficient practice). While onsite at the facility, the survey team verified and confirmed the facility's implementation of the IJRP through observation, interview, and record review. The survey team determined an IJ situation was no longer present and removed the IJ situation on [DATE] at 4:47pm in the presence of the administrator (ADM) and assistant administrator (AADM). A review of the IJRP included the following immediate actions: 1. On [DATE], the ice scoop and ice scoop container were placed in the kitchen dishwasher to be cleaned and sanitized. 2. On [DATE], the two ice chests in the north and south nursing stations were sanitized. 3. On [DATE], the ice machine located in the facility's dining room was locked and put into temporary out of service. 4. On [DATE], all residents' water pitchers and cups for 90 residents (total census) were replaced with new/uncontaminated water pitchers and cups. 5. On [DATE], The Dietary Supervisor (DS) in-serviced four dietary aides on the cleaning of the ice scooper and ice scooper container. 6. On [DATE], 200 pounds of ice was purchased by the ADM. 7. On [DATE], a new ice scooper and container sanitation log was created for the dietary aides on duty to log in the time of the day when they sanitize the ice scooper and the ice scooper container. The DS would check the log to ensure the ice scooper and the ice scooper container were sanitized daily. 8. On [DATE], a water company service had been contracted and scheduled maintenance of the ice machine and replacement of water filter every six months. 9. On [DATE], the facility's (P&P) titled, Cleaning and Sanitizing the Ice Scooper and Container for Ice Machine, was revised to include daily cleaning of the ice scooper, the ice scooper container and document in the cleaning log. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	10. On [DATE], a new clear ice scooper container with lid and new ice scooper was purchased. Findings: A. During a concurrent observation and interview on [DATE] at 8:47 am with the DS inside the facility's dining room, the facility had one ice machine as the source of ice for all 90 residents in the facility. There was one ice scoop used to transfer ice from the ice machine to the two ice chests (ice containers) and one ice scooper container to hold the ice scoop. The ice scooper container was mounted on the wall, five feet (ft, unit of measurement) above the floor and was removable. The ice scooper container was blue in color and was not transparent. The ice scooper container lid was not able to close completely. The DS removed the ice scooper container and refused to show it to the surveyor. The DS stated the ice scooper container was dirty with brown-colored liquid substance at the bottom. The DS stated the brown colored liquid substance was approximately 100 ml. The DS stated the ice scoop was touching the brown liquid substance inside the ice scooper container. During a concurrent observation of the ice scooper container in the dining room and an interview on [DATE] at 10:12 am with the Dishwasher Staff (DWS), the DWS looked at the ice scooper container with brown liquid and stated, Eww (used to express disgust or distaste). When the DS handed the ice scooper container to the DWS, the DWS stated the ice scooper container was nasty and dirty. The DWS stated the liquid substance inside the ice scooper container was brown in color, dirty and was not the normal color of water. During a concurrent interview and record review on [DATE] at 10:15 am with the DS, the Ice Machine Scoop Sanitation Log (IMSSL) for the months of May and [DATE] were reviewed. The DS stated there were no records of the ice scooper container sanitation log. The DS stated she did not know when the ice scooper container was cleaned and sanitized. The DS stated ice from the ice machine were transferred to the ice chests using the contaminated ice scoop. The DS stated each nursing station (North and South Nursing Station) had one ice chest. The DS stated she did not know what was in the brown liquid substance at the bottom of the ice scooper container. The DS stated the DS did not know how long the brown liquid substance had been in the ice scooper container. The DS stated the ice scoop inside the ice scooper container was touching the brown liquid substance and the contaminated ice scooper was used to scoop ice from the ice machine all day ([DATE]). The DS stated the ice were contaminated. The DS stated contaminated ice could cause the residents to get sick with water related illnesses such as diarrhea (loose stools) and or vomiting. During an interview on [DATE] at 10:27 am with the facility's Infection Preventionist Nurse (IPN- a nurse who help prevent and identify the spread of infectious disease in the healthcare environment), the IPN stated the ice scoop and ice scooper container needed to be cleaned and sanitized daily to prevent contamination of the ice which could result in water-borne illnesses. During an interview on [DATE] at 10:40 am with Resident 2, Resident 2 stated Resident 2 drank water with ice during breakfast. During an interview on [DATE] at 10:45 am with Resident 37, Resident 37 stated Resident 37 drank water with ice during breakfast. During an interview on [DATE] at 10:49 am with Resident 36, Resident 36 stated Resident 36 drank water with ice during breakfast. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 10:54 am with Resident 290, Resident 290 stated Resident 290 always ask water with ice with every meal and drank the iced water during breakfast. During a concurrent review of the facility's list of residents who received ice, dated [DATE] and lunch observation on [DATE] from 12 noon to 12:55 pm, the facility's list of residents indicated 42 of 90 residents (Residents 1, 2, 3, 4, 5, 6, 8, 11, 12, 13, 16, 17, 18, 20, 22, 23, 25, 27, 29, 36, 37, 38, 43, 46, 53, 54, 57, 58, 63, 64, 68, 71, 75, 76, 80, 84, 188, 189, 190, 238, 290 and 291) in the facility received ice from the ice chests. CNAs 1, 2 and 3 distributed contaminated ice from the two ice chests from the North and South Nursing Station to Residents 1, 2, 3, 4, 5, 6, 8, 11, 12, 13, 16, 17, 18, 20, 22, 23, 25, 27, 29, 36, 37, 38, 43, 46, 53, 54, 57, 58, 63, 64, 68, 71, 75, 76, 80, 84, 188, 189, 190, 238, 290 and 291. During an interview on [DATE] at 12:02 pm with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated, CNA 1 got ice from the ice machine in the dining room and used the contaminated ice scoop to fill up the ice chest with ice for the South Nursing Station. During an interview on [DATE] at 12:10 pm with CNA 2, CNA 2 stated, she used the contaminated ice scoop inside the ice scooper container that had brown liquid substance to scoop ice for the residents. During an interview on [DATE] at 12:19 pm with CNA 3, CNA 3 stated, she filled up the ice chest for the North Nursing Station with ice from the ice machine using the contaminated ice scoop inside the ice scooper container. During an interview on [DATE] at 5:34 pm with the Director of Nursing (DON), the DON stated a dirty ice scoop could contaminate the ice. The DON stated contaminated ice could cause the residents to get sick with water-borne illnesses such as abdominal pain or diarrhea and would result to hospitalization . During a review of the facility's undated policy and procedure (P&P) titled, Cleaning and Sanitizing Ice Scooper and Container for Ice Machine, the P&P indicated, Ice scooper and ice scooper container, located next to the ice machine, must be washed and sanitized daily in the dietary department dishwasher. During a review of an article titled, Ice Machines and Food Safety (plus, How to Sanitize), dated [DATE], the article indicated for safe handling, ice scoop should be cleaned and sanitized at least daily. https://foodsafepal.com/ice-machines-food-safety/#:~:text=Like%20a%20spatula%2C%20pair%20of, sanitize%20it%20at%20least%20daily. B.1. During an initial tour of the kitchen on [DATE] at 8:46 am with the Dietary Supervisor (DS), one of two kitchen freezers had two boxes of frozen pies and one bag of frozen strawberry fruits without label of the date when it was received. During an interview on [DATE] at 8:48 am with the DS, DS stated, food should be labeled with the date it was received to ensure the kitchen was serving food safe for the residents. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	B.2. During an initial tour of the kitchen on [DATE] at 8:51 am with the DS, the refrigerated storage had one gallon of plastic container, halfway filled with mixed and prepared thousand island dressing dated [DATE] and one gallon of plastic container, a quarter filled with mixed and prepared ranch dressing dated [DATE]. During an interview on [DATE] at 8:55 am with the DS, DS stated, mixed salad dressings had a shelf life of two weeks. DS stated mixed salad dressings should be discarded after its shelf life to prevent food-borne illnesses. During an interview on [DATE] at 11:47 am with the Lead [NAME] (LC), LC stated, he prepared the thousand island and ranch dressings. LC stated, thousand island and ranch dressings had a shelf life of two weeks. LC stated mixed and prepared salad dressings should be thrown away after two weeks because they were considered expired. LC stated residents could get sick when expired foods were consumed. During a review of the facility's shelf-life list of food, the shelf-life list indicated mixed salad dressings had a shelf life of two weeks when refrigerated. B.3.During an initial tour of the kitchen on [DATE] at 9:00 am with the Dietary Aide (DA) inside the canned and dry goods storage, one can of mixed fruit jelly and two bottles of grape concord jelly did not have a label with the date when it was received. During an interview on [DATE] at 9:03 am with the DA, DA stated, foods needed to be dated to guarantee older supply/stock would be used first. B. 4. During a concurrent observation and interview on [DATE] at 9:27 am inside the North Station medication room with Licensed Vocational Nurse 3 (LVN 3), a unit/snack refrigerator was located above the medication refrigerator. Inside the unit/snack refrigerator were a 12 ounces (oz, a unit of weight) plastic cup of cream-colored fluid covered with a saran wrap and labeled mocha mix without a date or name of the resident, a 64 fluid ounce (fl. oz) of opened, and unlabeled coffee French vanilla zero sugar, and a half peanut/butter jelly sandwich wrapped in saran wrap inside the freezer section of the unit refrigerator did not have a date or name of the resident. LVN 3 stated food should be labeled with the resident's name and date to determine who owned the food and when the food was opened or prepared. During a review of the facility's undated P&P titled, Sanitation and Infection Control-Freezer Storage, the P&P indicated, Upon receipt, frozen foods should be immediately stored in the freezer. Frozen food should be labeled with the date it was placed in the freezer. During a review of the facility's undated P&P titled, Sanitation and Infection Control-Canned and Dry Storage, the P&P indicated, New stock must be placed behind the old stock so oldest items will be used first. Products should be dated to assure FIFO-First in-First out. During a review of the facility's undated P&P titled, Sanitation and Infection Control-Refrigerated Storage, the P&P indicated, Leftover food or unused portions of package foods should be covered, labeled and dated to assure they will be used first. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of the facility's undated P&P titled, Food Receiving and Storage, the P&P indicated. All foods stored in the refrigerator or freezer will be covered, labeled, and dated (use by date). All foods belonging to residents must be labeled with the resident's name, the item, the date stored and the use by date. Stored food will be discarded after 3 days.

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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** 48905 Based on interview and record review the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of disease and infection by failing to: a. Establish facility wide systems and water safety management based on national standards of practice and the facility assessment for the prevention, identification, investigation, and control to prevent the growth of Legionella (bacteria that causes Legionnaires [severe form of pneumonia [lung infection caused by bacteria] and other opportunistic waterborne pathogens [any organisms or agent that can cause disease]) in the building water systems. b. Ensure signage was posted and personal protective equipment (PPE, specialized equipment or clothing that protects against infectious materials) cart was provided to one of one sampled resident (Resident 189) with Foley catheter (FC, thin, sterile tube inserted into the bladder to drain urine into a bag outside the body) who was on Enhanced Barrier Precaution (EBP, an approach for the use of PPE to reduce transmission of multi-drug resistant microorganisms [MDRO] between residents in skilled nursing facilities) in accordance with the facility's policy and procedure (P&P) on Enhanced Barrier Precaution and resident's care plan. These failures had the potential to result in cross contamination (movement of harmful bacteria from one object/person to another), development and transmission of infection and growth of infectious agents which could compromise the health and safety of residents and staff. Findings: a. During an interview on 6/7/2024 at 4:32 PM with the Administrator (ADM), the ADM stated the facility does not monitor water management because the facility does not have stagnant waters. The ADM stated there was no preventative processes to assess or measure the growth of Legionella and other waterborne opportunistic pathogens. The ADM stated the facility needed to have measures in place to monitor for legionella and infection. During an interview on 6/7/2024 at 5:04 PM with the Infection Preventionist Nurse (IPN- a nurse who helps prevent and identify the spread of infectious disease in the healthcare environment), the IPN stated the facility followed the policy and procedure (P&P) titled, Legionella Surveillance and Detection since it was a part of Infection Prevention. The IPN stated the facility does not have implementations for surveillance and detection of Legionella. During a review of the facility's policy and procedure (P&P) titled Legionella Surveillance and Detection, the P&P indicated as part of the Infection Prevention and Control Program, all cases of pneumonia that are diagnosed in residents 48 hours after admission will be investigated for possible Legionnaire's disease. The P&P indicated the facility was to prevent, detect and control water-borne contaminants, including Legionella. 40438 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 189's Admission Records (AR), the AR indicated Resident 189 was admitted to the facility on [DATE] with diagnoses that included urinary tract infection (UTI, an illness in any part of the urinary tract, the system of organs that makes urine) and benign prostatic hyperplasia (BPH, prostate gland enlargement that can cause urination difficulty). During a review of Resident 189's Minimum Data Set (MDS- a standardized assessment and care planning tool) dated 4/17/2024, the MDS indicated Resident 189 had intact cognition. Resident 189 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) with toileting, shower, upper and lower body dressing. During a review of Resident 189's untitled Care Plan (CP), dated 5/1/2024, the CP indicated Resident 189 was placed on EBP due to foley catheter. The CP interventions included continuous monitoring to ensure EBP was being observed, post signage on the door for everyone to see and proper wearing of PPE to anyone entering the room. The CP goal was to adhere to prevent cross infection. During an observation on 6/4/2024 at 9:26 am inside Resident 189's room, Resident 189 had a FC. Resident 189's room did not have an EBP signage posted outside the room and no cart for PPE was provided. During an interview on 6/4/2024 at 9:46 am with Registered Nurse Supervisor 3 (RN Sup 3), RN Sup 3 stated residents with FC should be on EBP and signage needed to be posted on the door for every staff to know to prevent the spread of infection. During an interview on 6/6/2024 at 8:39 am with the IPN, the IPN stated residents with FC had an increased risk of infection and should be on EBP. IPN stated signage should be posted on the door and a PPE cart should be outside the room to prevent cross contamination or infection. During a review of the facility's undated policy and procedure (P&P) titled, Enhanced Barrier Precautions, the P&P indicated, To reduce the transmission of MDROs by adhering to enhanced barrier precautions as clinically indicated during high contact care activities for residents with chronic wounds or indwelling medical devices. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gowns and gloves during high-contact resident care activities and signage posted outside the room door indicating the use of EBP.