STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056164	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Palms Healthcare	1020 Termino Avenue Long Beach, CA 90804

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49573 Based on observation, interview and record review, the facility failed to ensure residents' medical records were up to date as per the facility's policy and procedure (P&P) regarding advance directives (a legal document indicating resident preference on end-of-life treatment decisions) for two of seven sampled residents (Residents 18 and 83). These deficient practices violated the residents' right to be fully informed of the option to formulate an Advance Directive and had the potential to cause conflict with the residents' wishes regarding health care in the event residents became incapacitated (unable to participate in a meaningful way in medical decisions) or unable to make medical decisions that would not be identified and/or carried out by the facility staff. Findings: A. During a review of Resident 18's Admission Record, the Admission Record indicated Resident 18 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of heart failure (a heart disorder which causes the heart to not pump the blood efficiently), chronic obstructive pulmonary disease ([COPD] a chronic lung disease that makes it difficult to breathe), atrial fibrillation (an irregular and fast heartbeat in the upper part of the heart), depression (sad mood disorder), difficulty walking, and muscle wasting. During a review of Resident 18's Minimum Data Set ([MDS], a federally mandated resident assessment tool), dated 4/23/2024, the MDS indicated Resident 18 was moderately impaired in cognitive (though process) skills for daily decision-making and needed maximal assistance with self-care abilities such as oral hygiene, toileting, shower/bathing, dressing and functional abilities such as rolling left and right, sitting, and transferring. During a concurrent observation and interview on 10/06/2024 at 11:10 a.m., with Resident 18 in her room, Resident 18 was resting in bed. Resident 18 was alert and oriented to person and place, the resident knew who she was and what city she was in but did not know the name of the facility she was in or why she was in the facility, and what time of day it was. (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 - Some	During a concurrent interview and record review on 10/08/2024 at 11:28 a.m., with the Social Service Director (SSD), the Advance Directive Acknowledgement form, dated 11/19/2022 was reviewed. The SSD stated Resident 18 does not have the capacity to execute an Advance Directive. The SSD stated the Advance Directive acknowledgement form was filled out in 2022 and the SSD stated she was not aware of who filled out the form. The SSD also stated the Advance Directive acknowledgement form was not valid the way it was and should have been discussed with Resident 18's responsible party (RP). The RP would need to fill out the Advance Directive acknowledgement form. B. During a review of Resident 83's Admission Record, the Admission Record indicated Resident 83 was admitted on [DATE] with diagnoses of type 2 diabetes mellitus ([DM], a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension ([HTN], high blood pressure), and anxiety disorder (a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation). During a review of Resident 83's MDS dated [DATE], the MDS indicated Resident 83 was severely impaired in cognitive skills for daily decision making and was dependent on staff for self-care abilities such as oral hygiene, toileting, shower, and dressing and on functional abilities such as rolling left and right, sitting, and transferring. During a concurrent observation and interview on 10/7/2024 at 9:13 a.m., with Resident 83 in her room, Resident 83 was lying in bed with eyes closed. Resident 83 did not open eyes when asked how the resident was doing today and the resident did not respond back. During a concurrent interview and record review on 10/10/2024 at 11:28 a.m., with the SSD, the Advance Directive acknowledgement form for Resident 83, dated 9/11/2024 was reviewed. The SSD stated the Advance Directive acknowledgement form indicated the resident or RP had not executed an Advance Directive and do not wish to do so at this time. The Advance Directive acknowledgment form indicated verbal consent by a family member, but the facility does not know which family member it that the SSD spoke to. The SSD stated she does not know if the consent was a verbal consent over the phone or verbal consent in person as the form did not indicate so. The SSD stated the AD acknowledgement form was incomplete and not valid and another form would need to be completed. During an interview and record review on 10/10/2024 at 3:44 p.m., with the Director of Nursing (DON), the DON stated if a resident is not able to fill out the Advance Directive acknowledgement form, the RP would fill it out. The DON stated the importance for residents to have an AD so the facility will know what the resident's or family wants in terms of treatment for end-of-life care. During a review of the facility's policy and procedure (P&P), titled Advance Directive, revised in December 2016, indicated The resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so .if resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the resident's legal representative . prior to or upon admission of the resident, the Social Service Director or designee will inquire of the resident, his/her family members and/or his or her legal representative about the existence of any written advance directive . information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45777 49573 Based on interview and record review, the facility failed to provide accurate information in the Minimum Data Set ([MDS], a federally mandated resident assessment tool) assessment for two of three sampled residents (Resident 81, and Resident 83). This deficient practice had the potential to result in inaccurate care and services for the residents due to inappropriate MDS assessment and care screening tool practices. Findings: A. During a review of Resident 81's Admission Record, the Admission Record indicated Resident 81 was originally admitted on [DATE] with a re-admitted on 5/31/2023 with diagnoses of atrial fibrillation (a condition that causes irregular and fast heartbeat in the heart), congestive heart failure ([CHF], when the heart cannot pump enough blood to meet the body's needs), type 2 diabetes mellitus ([DM], a disorder characterized by difficulty in blood sugar control and poor wound healing) , depression (sad mood disorder), dementia (a gradual decline in cognitive abilities such as thinking, remembering and reasoning), obstructive sleep apnea ([OSA], common sleep disorder that causes the upper airway to partially or completely collapse during sleep), and obesity (a disease when a person has too much body fat). During a review of Resident 81's MDS, dated [DATE], the MDS indicated Resident 81 was moderately impaired in cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making and was maximal assistance (helper does more than half the effort in assisting to complete the task) on self-care abilities such as oral hygiene, toileting, shower, and dressing and on functional abilities such as rolling left and right, sitting, and transferring. The MDS also indicated that the bedrails were not being used. During an observation on 10/6/2024 at 12:24 p.m., in Resident 81's room, Resident 81 was resting in bed watching television. The two upper side rails were up. During a concurrent interview and record review on 10/9/2024 at 10:40 a.m., with the MDS Coordinator (MDSC), Resident 81's order summary report dated 10/8/2024 was reviewed. The order summary report indicated both upper quarter rails were up to aid in turning and repositioning, informed consent obtained by Medical Doctor (MD) from responsible party (RP), risks and benefits explained. The MDSC stated the two upper side rails were being used for aiding and turning in bed and does not meet the criteria of restraint. The MDSC stated the side rails and consent for the side rails does not affect how the MDS was coded on the MDS assessment. During a review of the facility's policy and procedure (P/P) titled, Resident Assessments, revised November 2019, indicated the resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessment and reviews. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. During a review of Resident 83's Admission Record, the Admission Record indicated Resident 83 was admitted on [DATE] with diagnoses of type 2 diabetes mellitus, hypertension ([HTN], high blood pressure), anemia (a condition where the body does not have enough healthy red blood cells), anxiety disorder (a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation), insomnia (difficulty sleeping at night), and muscle weakness. During a review of Resident 83's MDS dated [DATE], the MDS indicated Resident 83 was severely cognitively impaired for daily decision making and was dependent (helper does all the effort in assisting to complete the task) on self-care abilities such as oral hygiene, toileting, shower, and dressing and on functional abilities such as rolling left and right, sitting, and transferring. The MDS also indicated the side rails were not being used in the bed. During an observation on 10/7/24 at 9:04 a.m. in Resident 83's room, Resident 83 was lying in bed with eyes closed. The two upper side rails were up. During a concurrent interview and record review on 10/9/2024 at 10:31 a.m. with the MDS Coordinator (MDSC), Resident 83's order summary report dated 9/9/2024 was reviewed. The order summary report indicated both upper quarter rails up, to aid in turning and repositioning, informed consent obtained by Medical Doctor (MD) from responsible party (RP), risks and benefits explained. The MDSC stated the two upper side rails were being used for aiding and turning in bed and does not meet the criteria of restraint. The MDSC stated the side rails and consent for the side rails does not affect how the MDS was coded on the MDS assessment. During a review of the MDS 3.0 Section P guidance, the guidance indicates that if the use of bed rails (quarter-, half- or three-quarter, one or both, etc.) meets the definition of a physical restraint even though they may improve the resident's mobility in bed, the nursing home must code their use as a restraint. During a review of the facility's Resident Assessment/Care Plan Coordinator (MDS) job description, no date, indicated, general duties and responsibilities included conduct or coordinate the interviewing of each resident for the resident's assessment ensure that all members of the assessment team are aware of the importance of competences and accuracy in their assessment functions and that they are aware of the penalties, including civil money penalties, for false certification inform all assessment team members of the requirements for accuracy and completion of the resident assessment (MDS). During a review of the facility's policy and procedure (P/P) titled, Resident Assessment, revised November 2019, indicated a change in status assessment is required when a resident begins to use a restraint of any type, when it was not used before.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45777 Based on observation, interview, and record review, the nursing staff failed to update and revise a fall risk care plan for two of three sampled residents (Resident 106 and 170). This deficient practice had the potential to place Residents 106 and 170 to be at risk for recurrent falls. Findings: a. During a review of Resident 106's admission record, the admission record indicated Resident 106 was initially admitted to the facility on [DATE] with a diagnoses of acquired absence of the right leg above the knee (amputation), Lack of coordination, and difficulty walking. During a review of Resident 106 's history and physical (H&P) dated 9/13/202 4, the H&P indicated resident 106 had the capacity to understand and make decisions. During a review of Resident 106's Minimum Data Set (MDS), a Federally mandated assessment tool, dated 7/31/2024, the MDS indicated Resident 106 required substantial /maximum assistance (helper lifts and hold the trunk or limbs, but provides less than half the effort) with upper and lower body dressing, and sit to stand. During a review of the Fall Risk Assessment (an evaluation of the likelihood of someone falling) dated 7/25/2024, the Fall Risk Assessment indicated Resident 106 had a score of 7 according to the Fall Risk Assessment Resident 106 was not a fall risk. During a review of the post Fall Risk assessment dated 9/ 21/2024, the Fall Risk Assessment indicated Resident 106 had a score of 7 according to the Fall Risk Assessment Resident 106 was not a fall risk. During a review of the Change in Condition Evaluation (COC a form used to document a significant change in a person's health) form, the COC indicated Resident 106 had a fall on 9/21/2024 at 11:30 a.m. b. During a review of Resident 170's admission record, the admission record indicated Resident 170 was initially admitted to the facility on [DATE], with diagnoses of dementia (loss of memory, language, problem solving and other thinking abilities that interfere with daily life), Alzheimer's disease (a decline in memory, thinking, learning and organizing skills over time) and hypertension (high blood pressure). During a review of Resident 170's MDS dated [DATE], the MDS indicated Resident 170 had severe cognitive impairment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 170's Fall Risk assessment dated [DATE], the Fall Risk Assessment indicated Resident 170 had a score of 13 according to the Fall Risk Assessment Resident 170 is a high risk for falls. During a record review of Resident 170's COC form, the COC indicated Resident 170 had a fall on 1/8/2024. During a review of the Post Fall Risk assessment dated [DATE], the Post Fall Risk Assessment indicated Resident 106 had a score of 10 according to the Fall Risk Assessment Resident 170 was at risk for fall. During an interview on 10/10/2024 at 11:51 a.m. with the Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated we enter an incident into Residents care plan if a concern is already there, we update the care plan. During a concurrent interview and record review on 9/10/2024 at 1:30 p.m., with the DSD (Director of Staff Development) Resident106's untitled care plan was initiated on 8/8/2024, the care plan indicated resident 106 is at risk for falls related to a balance problem during transition and assistance needed during walking and bed mobility. The DSD verified Resident 106's care plan was not revised to reflect the fall incident on 9/21/2024. During a concurrent interview and record review on 10/10/2024 at 4:30 p.m., with the Director of Nursing (DON), the DON verified Resident 106 and 170's care plans was not updated to reflect recent fall of Resident 106 on 9/21/2024 and Resident 170 on 1/8/2024. The DON stated it is important to update a resident's care plan to monitor which intervention is not working. During a review of the facility's policies and procedures (P&P) revised December 2016, titled Care Plans Baseline indicates the resident and their representatives will be provided a summary of a baseline care plan that includes but not limited to: Any updated information based on the details of the comprehensive care-plan, as necessary.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46537 Based on observation, interview, and record review, the facility failed to ensure following up with an optometrist (health care providers who examine, diagnose, treat, and manage diseases and disorders of the visual system, the eye and associated structures as well as diagnose related systemic conditions) visit in six months as recommended by the optometrist and referring to ophthalmologist (a specialist who can treat complex medical issues related to your eyes, and can perform corrective procedures or surgeries including cataracts [tissue that forms over the eye, causing vision loss) and glaucoma [built up pressure in the eye that causes gradual vision loss]) for one of six sampled residents (Resident 55). This failure had the potential to result in Resident 55 not receiving proper care to maintain and/or improve his vision. Findings: During a review of Resident 55's Admission Record, the Admission Record indicated, Resident 55 was initially admitted to the facility on [DATE] and last readmission was 4/2/2024 with diagnosis including end stage renal disease (irreversible kidney failure), diabetes mellites (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), left eye blindness, and glaucoma (a disease that damages your eye's optic nerve. It usually happens when fluid builds up and increases pressure inside the eye). During a review of Resident 55's History and Physical (H&P), dated 1/4/2024, the H&P indicated, Resident 55 had the capacity to understand and make decisions. During a review of Resident 55's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/16/2024, the MDS indicated Resident 55 required dependent assistance (Helper does all of the effort) from two or more staff for shower/bathe self, toilet transfer, maximal assistance (Helper does more than half the effort) from one staff for toileting hygiene, upper/lower body dressing, personal hygiene, bed mobility, moderate assistance (Helper does less than half the effort) from one staff for oral hygiene, and set up or clan up assistance (Helper sets up or cleans up) from one staff for eating. During a concurrent observation and interview on 10/6/2024, at 11:55 a.m., with Resident 55 in his room, Resident 55 was looking for his eyeglasses. Resident 55 stated, he was left eye blind because of glaucoma and diabetes and he wore special eyeglasses to adjust with lights and glare. Resident 55 stated, he was worried about losing his vision on the right side because he was seen by an ophthalmologist a long time ago. Resident 55 stated, the optometrist came to see him in March, but there was no follow up visit after that, and his right eye was getting blurry. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/8/2024, at 11:33 a.m., with Social Service Director (SSD), Resident 55's Eye Doctor Consultation Notes, dated 3/26/2024 was reviewed. The Eye Doctor Consultation Notes indicated, Resident 55 was diagnosed with glaucoma, presbyopia (the gradual loss of your eyes' ability to focus on nearby objects), dry eye, and pseudophakia (an artificial lens implanted after the natural eye lens has been removed). The Eye Doctor Consultation Notes indicated, next exam in six months. The SSD stated, she should have arranged Resident 55's follow up appointment in September and referred to specialist to prevent glaucoma and DM related complication such as diabetic retinopathy (a condition that may occur in people who have?diabetes, from getting worse. It causes progressive damage to the retina, the light-sensitive lining at the back of the eye). During an interview on 10/8/2024, at 3:00 p.m., with Registered Nurse Supervisor (RNS) 2, RNS 2 stated, Resident 55 should have been seen by the specialist (ophthalmologist) to prevent further vision loss because his diagnoses of glaucoma and DM. RNS 2 stated, Resident 55's concerns regarding his right eye should have been addressed sooner since he lost his vision on left side due to same issue. During an interview on 10/10/2024, at 12:43 p.m. with Director of Nursing (DON), the DON stated, the SSD should have followed up with the optometry visit in September to ensure Resident 55 was seen by the optometrist and referred to the ophthalmologist regarding blurry vision. The DON stated, if the follow ups and referrals were not done in a timely manner, Resident 55 might lose his vision on right eye, and this will greatly affect his ability to do Activities of Daily Living (ADL). During a review of Resident 55's Order Summary Report (OSR), dated 10/8/2024, the OSR indicated a physican's order dated 4/2/2024 for Brimonidine Tartrate (a medication to lower pressure in the eyes) Ophthalmic Solution (liquid eye drop) 0.2 percent (%) one drop in both eyes every eight hours for glaucoma. The OSR indicated, Dorzolamide HCL (a medication to treat high pressure inside the eyes) Ophthalmic Solution 2% one drop in both eyes two times a day for glaucoma was ordered on 5/16/2024. During a review of Resident 55's Interdisciplinary (IDT- a group of health care professionals working collaboratively toward a common goal) Team Meeting Notes, dated from 3/2024 to 9/2024, the IDT Notes indicated, there was no discussion regarding Resident 55's follow-up visit with Optometry and Ophthalmologist referral. During a review of Resident 55's untitled Care Plan (CP), initiated 1/3/2024, the CP Focus indicated, Resident 55 was at risk for injury due to impaired visual functioning secondary to glaucoma, left eye blindness, and DM. The CP Interventions indicated, provide medications (Brimonidine and Dorzolamide) as ordered and monitor for eye pain/problem. The CP interventions indicated; Optometry referral as indicated. During a review of the facility's Policy and Procedure (P&P) titled, Ancillary Services, dated 5/2019, the P&P indicated, Policy: it is the policy of this facility to obtain dental, optometry, ophthalmology, podiatry, audiology (ENT) and psychological/psychiatric services for residents who present with or request a need for these ancillary services. RATIONALE: Ancillary services help residents attain and maintain healthy psychosocial functioning through their ability to interact with their environment. PROCEDURE: All residents will be assessed for ancillary needs upon admission, and reassessed quarterly and as needed. Dental evaluation should be done at least annually . Social Services will maintain records indicating when services (routine and non-routine) are due and when provided . Social Services will coordinate efforts with the ancillary service providers on recommended follow up until the need is met. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure (P&P) titled, Social Service Department Role &Function, dated 11/2019, the P&P indicated, POLICY: It is the policy of this facility to provide medically related social services to all residents in an effort to help them achieve and maintain their highest practicable level . PROCEDURE: Medically-related social services means services provided by the facility's staff to as sist residents in maintaining or improving their ability to manage their everyday physical, mental, and psychosocial needs. These services might include, for example: of physical, mental, and psychosocial functioning, within scope of accepted social work practice . Making referrals and obtaining services from outside entities (e.g., talking books, absentee ballots, community wheelchair transportation . Finding options which most meet their physical and emotional needs -Factors with a potentially negative effect on physical, mental, and psychosocial wellbeing include an unmet need for: Dental /denture care; Podiatry care; Eye Care; Hearing services.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415 46537 Based on observation, interview, and record review, the facility failed to follow through Registered Dietitian (RD-a health professional who has special training in diet and nutrition)'s recommendations in a timely manner and failed to assess, monitor, and evaluate interventions to prevent two of nine sampled residents (Resident 42 and 79) from further weight loss by: A. Failing to ensure to monitor and assess Resident 42's weekly weights and intake of supplements, and obtain an order for Megestrol Acetate (a medication to treat loss of appetite and weight loss) in a timely manner as recommended by the RD. B. Failing to ensure Resident 79 received the boost glucose control (a nutritional drink designed to help people with type 2 diabetes [uncontrolled blood sugar] increase their nutrient consumption while maintaining their blood sugar levels) as recommended by the RD due to a significant weight loss. This failure resulted in placing Resident 42 and 79 at risk for continued weight loss. Findings: A. During a review of Resident 42's Admission Record, the Admission Record indicated, Resident 55 was initially admitted to the facility on [DATE] and last readmission was 7/26/2024 with diagnoses including dementia (a progressive state of decline in mental abilities), dysphagia (difficulty swallowing), lack of coordination, and Pressure induced deep tissue damage (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) of sacral region (the portion of the spine between lower back and tailbone). During a review of Resident 42's History and Physical (H&P), dated 7/29/2024, the H&P indicated, Resident 42 did not have the capacity to understand and make decisions. During a review of Resident 42's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 8/21/2024, the MDS indicated Resident 42 required maximal assistance (Helper does more than half the effort) from one staff for toileting hygiene, lower body dressing, personal hygiene, bed mobility, and moderate assistance (Helper does less than half the effort) from one staff for eating. The MDS section K (swallowing/Nutritional Status) indicated, Resident 42 had a weight loss of five percent (%) or more in the last month or a weight loss of 10 % or more in last six months and Resident 42 was not on physician prescribed regimen to improve Resident 42's weight loss. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Palms Healthcare	1020 Termino Avenue Long Beach, CA 90804

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 10/7/2024, at 12:35 p.m., with Licensed Vocational Nurse (LVN) 4 in the dining room, LVN 4 was assisting Resident 42 with feeding. Resident 42 was yelling and very confused. LVN 4 stated, Resident 42 ate 75 % of the meal, but she took a few sips of Boost Plus (a nutrient -packed, high calorie nutritional supplement drink) only because she was too full. LVN 4 stated, she did not document the amount of Boost Plus that Resident 42 drank during lunch. LVN 4 stated, she told Certified Nurse Assistant (CNA) to record the percentage of meal that Resident 42 consumed. During a concurrent interview and record review on 10/7/2024, at 3:08 p.m., with the RD, Resident 42's Dietary Notes, dated from 7/16/2024 to 9/17/2024 were reviewed. The DN indicated, Resident 42's calorie requirement was 1762 kilocalories (kcal- The term used to represent the amount of energy required to raise the temperature of a liter of water one degree centigrade at sea level) on 7/16/2024 and 1713 kcal on 9/17/2024. The RD stated, Resident 42 was continuing to lose weight, and calorie requirements were getting less because she calculated based on the resident's current weight, not based on the resident's ideal weight. During a concurrent interview and record review on 10/7/2024, at 3:15 p.m., with the RD, Resident 42's Dietary Notes, dated 7/16/2024 to 9/17/2024 were reviewed. The RD stated, she recommended an appetite stimulant (Megestrol Acetate) on 8/6/2024 during the weight variance meeting (an interdisciplinary team meeting to discuss and evaluate the residents' weight changes), but the physician ordered it on 8/29/2024. The RD stated, Nursing staff should have contacted physician to get an order for the appetite stimulant and carried out her recommendation right away. The RD stated, nursing staff should have measured Resident 42's weekly weight and recorded the amount of supplement drinks (Boost plus and health shakes-supplements for adding dietary calories and protein) consumed by Resident 42 to assess and evaluate interventions for effectiveness. During a concurrent observation and interview on 10/8/2024, at 12:26 p.m., with the Quality Assurance Nurse (QA), in the dining room, the QA was assisting Resident 42 with feeding. Resident 42 ate 75% of the meal and drank four ounces of juice. Resident 42 took a sip of Boost Plus and spat it out right away. The QA stated, Resident 42 took few sips of Boost Plus because she was too full. The QA stated, it would be better if she could get the Boost Plus between meals, not with the meals. During a concurrent interview and record review on 10/8/2024, at 3:10 p.m., with Registered Nurse Supervisor (RNS) 2, Resident 42's Medication Administration Record (MAR), dated 10/2024 was reviewed. The MAR indicated, health shakes, eight ounces were given at 10:00 a.m., 2:00 p.m., and 8:00 p.m. daily. The MAR did not indicate how much of each health shake Resident 42 consumed. RNS 2 stated, staff only document whether it was given or not, but staff did not document the amounts that Resident 42 consumed. RNS 2 stated, he would document it as 'given' (the whole drink consumed) even though Resident 42 took only a few sips of the health shakes. RNS 2 stated, there was no order to measure Resident 42's weekly weight. RNS 2 stated, staff should have followed up and notified the physician to order weekly weights and to document percentage of intake of the supplements to evaluate the progress of weight changes. During an interview on 10/9/2024, at 11:52 a. m. with Director of Staff Development (DSD), the DSD stated, RD recommendation should have been carried out as soon as possible to prevent delay of care and provided Boost plus between meals to increase the consumption. DSD stated, weight variance meeting should have evaluated outcomes from interventions by using weekly weight and the amounts of Resident 42's intakes. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/10/2024, at 3:44 p.m., with the Director of Nursing (DON), the DON stated, staff should have documented the portion of supplements Resident 42 consumed. The DON stated, there was no data recorded to be able to evaluate the effectiveness of the interventions since there was no weekly weight and amount of intake documented. The DON stated, the RD should have provided more calories and should have used ideal weight (a person's estimated weight that is associated with a healthy weight range for their height, ages, sex and frame size [Resident 42's goal weight-130 pounds]) instead of Resident 42's current weight to calculate the caloric requirements to improve weight status. The DON stated, RD's recommendation should have been carried out in timely manner to prevent a delay in treatment, and this could place the resident at risk for further weight loss. The DON stated, excessive weight loss could worsen the pressure injury (skin and tissue damage especially around bony areas due to continuous pressure) and serious complications. During a review of Resident 42's Order Summary Report (OSR), dated 10/8/2024, the OSR indicated: -Boost Plus with nectar thick liquid (liquids that has been altered to a thicker consistency than water) eight ounce three times with meals for supplement ordered on 8/31/2024. -Health shakes with nectar thick liquid eight ounce three times a day between meals for supplement ordered on 9/19/2024. -Megestrol Acetate 400 milligram/10 milliliter by mouth two times a day for appetite stimulant was ordered on 8/29/2024. During a review of Resident 42's Weights and Vitals Summary (WVS), dated 10/8/2024, the WVS indicated, Resident 42 weighed 122 pounds (lbs) on 5/2/2024 and weighed 112 lbs on 10/04/2024, which was 8.20 % weight loss in six months. The WVS indicated as following: On 5/2/2024 weight was 122 Lbs. On 6/3/2024 weight was 118 Lbs. On 6/19/2024 weight was 118 Lbs. On 6/26/2024 weight was 118 Lbs. On 7/3/2024 weight was 121 Lbs. On 7/10/2024 weight was 117 Lbs. On 7/28/2024 weight was 115 Lbs. On 8/5/2024 weight was 115 Lbs. On 8/13/2024 weight was 113 Lbs. On 8/19/2024 weight was 111 Lbs. On 8/26/2024 weight was 112 Lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/10/2024 weight was 111 Lbs. On 10/4/2024 Resident 42's weight was 112 lbs. which was the last recorded weight at the facility. During a review of Resident 42's untitled Care Plan (CP), initiated on 4/5/2024, the CP Focus indicated, Resident 42 was at risk for altered nutritional status as evidenced by history of weight loss. The CP Interventions indicated, monitor weight per protocol, provide Megestrol Acetate, health shakes, and Boost Plus supplement as ordered. During a review of Resident 42's untitled CP, initiated 7/27/2024, the CP Focus indicated, Resident 42 exhibits poor oral intake and refuses to take food for all mealtimes. The CP Interventions indicated, assess for risk for impaired nutrition less than body requirement, feeder during mealtime, and monitor oral intake for every meals. B. During a review of Resident 79's Admission Record, the Admission Record indicated Resident 79 was initially admitted to the facility on [DATE] and last readmission was 3/9/2024 with diagnoses including muscle wasting on the upper right and left arm, congestive heart failure (CHF: occurs when the heart cannot pump enough blood to meet the body's needs), Type II Diabetes Mellitus and unspecified protein-calorie malnutrition (lack of proper nutrition). During a review of Resident 79's MDS dated [DATE], the MDS indicated Resident 79's cognitive skills (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) were intact. The MDS indicated Resident 79 required maximal assistance for chair-bed to chair transfer, toilet transfer, toilet hygiene and bathing. Required moderate assistance for lower body dressing, and required supervision for oral and personal hygiene, and upper body dressing. The MDS indicated, Resident 79 had a loss of five percent (%) or more weight in the last month or loss of 10 % or more in last six months was on a physician prescribed regimen to improve Resident 79's weight loss. During a review of Resident 79's untitled CP initiated on 3/11/2024, the CP Focus indicated Resident 79 was at risk for altered nutritional status, dehydration electrolyte (a substance in the body that facilitate functions in the body) imbalance, and significant weight changes related to (r/t) fluid accumulation (CHF) and malnutrition. The CP Interventions indicated to monitor weight per protocol and Boost Glucose Control as ordered. The CP Initiated on 6/12/2024 indicated Resident 79 had a weight loss of seven (7) lbs. in one (1) month (three percent) with a resolve date of 9/12/2024. The CP Interventions indicated to monitor weights and report a five lb weight loss to the medical doctor (MD) and dietitian promptly. During a review of Resident 79's OSR, the OSR indicated an active order of Boost Glucose Control three times a day for supplement with meals dated 10/4/2024. The OSR initially indicated a Boost Glucose Control two times a day on 8/15/2024. During a review of Resident 79's WVS, the WVS indicated Resident 79 weighed 251 lbs. on 4/2/2024 and weighed 223 lbs. on 10/4/2024, which was 11.16 % weight loss in six months. The WVS indicated as following: On 10/4/2024: 223.0 Lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/10/2024: 225.0 Lbs. On 8/6/2024: 228.0 Lbs. On 7/2/2024: 234.0 Lbs. On 6/11/2024: 240 Lbs. On 5/7/2024: 247.0 Lbs. On 4/2/2024: 251.0 Lbs. During a concurrent interview and record review on 10/7/2024 at 1:29 p.m., with Registered Dietitian (RD), RD stated if a resident has significant weight changes, the Interdisciplinary Team (IDT - Resident's healthcare team consisting of various specialties) will determine if a resident needs to be on weekly weights to monitor, review, and assess if their interventions are working. The RD stated since Resident 79 continued to lose weight she recommended on 8/13/2024 to add boost glucose control twice a day and to discontinue diuretics (medication used to remove excess fluids from the body). The RD stated Resident 79's weight has been trending down having lost 28 lbs. in 6 months, which is considered a significant weight loss, and indicated Resident 79 would have benefited from having a weekly weight done compared to being weighed monthly. During a concurrent interview and record review on 10/10/2024 at 4:30 p.m., with QA, QA stated the Dietary Note dated 8/13/2024 indicated the recommendation was to discontinue fluids, order labs, and start boost glucose control twice a day with lunch and dinner. QA stated when there is a recommendation, they will inform the doctor, and once the doctor agrees with the recommendation, an order will be placed. QA stated they had an updated order regarding the boost glucose control on 10/5/2024. QA stated the order for boost control glucose was initiated on 8/15/2024 but was discontinued on 8/15/2024. QA stated based on the progress note on 8/15/2024, the doctor agreed to do the labs since it was completed on 8/15/2024 but is not sure what occurred regarding the order for the boost glucose control. QA stated there are no documentation regarding the boost glucose control and there are no indicating rational as to why the boost glucose control was discontinued on 8/15/2024. The QA stated Resident 79 should have gotten the boost glucose control back in August as recommended by the RD. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policy and Procedure(P&P) titled, Weight Assessment and Intervention, revised 9/2008, the P&P indicated, Policy Statement: The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents .Weight Assessment .3. The Dietitian will review the unit Weight Record by the 15th of the month to follow individual weight trends overtime. Negative trends will be evaluated by the treatment team whether or not the criteria for significant weight change has been met . Analysis:1. Assessment information shall be analyzed by the multidisciplinary team and conclusions shall be made regarding the: a. Resident's target weight range (including rationale if different from ideal body weight); b. Approximate calorie, protein, and other nutrient needs compared with the resident's current intake; c. The relationship between current medical condition or clinical situation and recent fluctuations in weight; and d.Whether and to what extent weight stabilization or improvement can be anticipated .Care planning: individualized care plans shall address, to the extent. Possible: a. The identified causes of weight loss; b. Goals and benchmarks for improvement; and c. Time frames and parameters for monitoring and reassessment . Interventions: I. Interventions for undesirable weight loss shall be based on careful consideration of the following: a. Resident choice and preference: b. Nutrition and hydration needs of the resident; c. Functional factors that may inhibit independent eating: d. Environmental factors that may inhibit appetite or desire to participate in meals: e. Chewing and swallowing abnormalities and the need for diet modifications: f. Medications that may interfere with appetite, chewing, swallowing, or digestion; g. The use of supplementation and/or feeding tubes; and h. End of life decisions and advance directives. During a review of the facility's Policy and Procedure(P&P) titled, Nutritional Assessment, revised 9/2011, the P&P indicated, Policy Statement: A nutritional assessment, including current nutritional status and risk factors for impaired nutrition, shall be con ducted for each resident. Policy Interpretation and Implementation . 3. Dietitian: a. An estimate of calorie, protein, nutrient and fluid needs; b. Whether the resident's current intake is adequate to meet his or her nutritional needs; and c. Special food formulations. 4. The multidisciplinary team shall identify, upon the resident's admission and upon his or her change of condition, that place the resident at increased risk for impaired nutrition. During a review of the facility's Policy and Procedure(P&P) titled, Job Description: Dietary Consultant, dated 2011, the P&P indicated, Responsibilities: 1. Evaluates the nutritional needs of residents/patients and documents in the nutritional record.

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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. 40994 Based on observation, interview, and record review, the facility failed to accurately account for one dose of a controlled medication (medications with a high potential for abuse) affecting Residents 10 in one of two inspected medication carts (West Station Cart 1.) This deficient practice increased the risk of diversion (any use other than that intended by the prescriber) of controlled mediations and the risk that Resident 10 could have received too much or too little medication due to lack of documentation possibly resulting in serious health complications requiring hospitalization . Findings: During an observation and concurrent interview of [NAME] Station Cart 1, on 10/7/24 at 1:12 PM, with the Licensed Vocational Nurse (LVN 1) the following discrepancies were found between the Narcotic and Hypnotic Record (a log signed by the nurse with the date and time each time a controlled substance is given to a resident) and the medication card (a bubble pack from the dispensing pharmacy labeled with the resident's information that contains the individual doses of the medication): 1. Resident 10's Narcotic and Hypnotic Record for morphine sulfate ER (a medication used to treat pain) 15 milligrams (mg - a unit of measure for mass) indicated there were two doses left, however, the medication card contained one dose. During a concurrent interview, LVN 1 stated she administered the missing dose of Resident 10's morphine earlier this morning but failed to sign the Narcotic and Hypnotic Record at that time. LVN 1 stated she is required to sign the log before the medication is administered to ensure accountability for narcotics. LVN 1 stated failing to sign the log may result in the resident receiving a controlled substance more often than prescribed which could lead to medical complications. A review of the facility's policy Controlled Substances, revised April 2019, indicated .Controlled substances are reconciled upon . administration . Upon administration, the nurse administering the medication is responsible for recording: .time of administration .quantity of the medication remaining, and signature of the nurse administering medications .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on interview and record review, the facility failed to ensure the physician responded to the consultant pharmacist's recommendation from 8/3/24 to consider a gradual dose reduction (GDR - a periodic attempt to manage a resident's behavioral issues with a lower dose of medication) related to the use of Depakene solution (a medication used to treat mood swings) in one of five sampled residents (Resident 65.) The deficient practice of failing to ensure the physician evaluated and responded to medication irregularities (potential issues with a resident's medication regimen) identified by the consultant pharmacist during the Medication Regimen Review (MRR - a monthly report from the consultant pharmacist identifying any medication irregularities in a resident's current medication regimen) increased the risk that Resident 65 could have experienced adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to their medication therapy possibly leading to impairment or decline in their mental or physical condition or functional or psychosocial status. Findings: During a review of Resident 65's Admission Record (a document containing diagnostic and demographic information), dated 10/8/24, indicated she was admitted to the facility on [DATE] with diagnoses including bipolar disorder (a mental illness characterized by mood swings from manic highs to depressive lows.) During a review of Resident 65's History and Physical (H&P - a record of a comprehensive physician's assessment), dated 4/15/24, confirmed this resident's diagnosis of bipolar disorder. During a review of Resident 65's Order Summary Report (a summary of all currently active physician orders), dated 10/8/24, indicated on 8/22/22, Resident 65 was prescribed Depakene 250 milligrams (mg - a unit of measure for mass) per 5 milliliters (ml - a unit of measure for volume) to take 10 ml by mouth one time a day for bipolar disorder manifested by yelling/screaming. During a review of the consultant pharmacist's recommendation, dated 8/3/24, indicated the consultant pharmacist asked the physician to consider reducing the dose of Resident 65's Depakene solution or to indicate a clinical rationale as to why an attempt would be clinically contraindicated. During a review of Resident 65's clinical record, no documentation was found indicating the physician responded to the consultant pharmacist's request to consider a GDR for Depakene solution. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/08/24 at 10:03 AM, the Director of Nursing (DON) stated the facility failed to ensure the physician responded to the consultant pharmacist's request to decrease the dose of Depakene for Resident 65. The DON stated the GDR request addressed two different medications, but the GDR was only performed on one of them. The DON stated there is no record of a specific response to the pharmacist's request or any other record that addresses the dosage of Depakene specifically and the resident has been on the same dose since August of 2022. The DON stated the facility failed to decrease the dose or document a dosage reduction would be contraindicated for resident-specific reasons. The DON stated the failure to consider a GDR or respond to the pharmacist's request for GDR increased the risk that Resident 65 may have experienced adverse effects of Depakene, such as increased sedation, due to using a higher dose than necessary which could have negatively impacted her quality of life. During a review of the facility's policy Pharmacy Services - Role of the Consultant Pharmacist, revised April 2019, indicated Upon receipt of the pharmacy recommendation, the facility will assign a licensed nurse or nurses to contact the prescribers and address the specific recommendations . The prescriber's response will be documented on the recommendations or in the resident's medical record. In the event the prescriber does not respond within 10 business days, the prescriber will be contacted again for follow-up. Record of the follow-up will be kept in a binder for review, or in the specific resident's medical record .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on interview and record review, the facility failed to discontinue hydroxyzine (a medication used to treat itching and allergies) per the physician's order due to non-use in one of five residents sampled for unnecessary medications (Resident 40.) The deficient practice of failing to discontinue the use of hydroxyzine when Resident 40 was simultaneously using another medication to treat itching effectively could have increased the risk that Resident 40 may have experienced adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to the use of hydroxyzine possible resulting in a decline in her quality of life. Findings: During a review of Resident 40's Admission Record (a document containing diagnostic and demographic information), dated 10/8/24, indicated she was admitted to the facility on [DATE] with diagnoses including multiple sclerosis (a neurological condition causing muscle weakness.) During a review of Resident 40's History and Physical (H&P - a record of a comprehensive physician's assessment), dated 2/22/24, indicated she had the capacity to understand and make decisions. During a review of Resident 40's Order Summary Report (a summary of all currently active physician orders), dated 10/8/24, indicated on 10/5/24, Resident 40 was prescribed hydroxyzine 50 milligrams (mg - a unit of measure for mass) by mouth every six hours as needed for itching for 14 days. During a review of Resident 40's Order Summary Report, dated 10/8/24, indicated on 6/11/24, Resident 40 was prescribed Benadryl (a medication used to treat itching and allergies) 50 mg by mouth every six hours as needed for itching or allergies. During a review of Resident 40's Medication Administration Report (MAR - record of all medications administered to a resident) between 8/1/24 and 10/8/24 indicated that, although Resident 40 has continually had an active physician order for hydroxyzine, she had never been administered a dose in that time frame. During a review of the consultant pharmacist's recommendation, dated 8/3/24, indicated the consultant pharmacist made a recommendation to the physician to consider discontinuing Resident 40's order for hydroxyzine due to non-use and the fact that itching was being effectively treated with Benadryl. Further review of the pharmacist's recommendation indicated the physician agreed to discontinue hydroxyzine if it was not being used but the facility documented that the resident declined to have it discontinued because she still uses this. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/08/24 at 10:17 AM, the Director of Nursing (DON) stated the facility failed to discontinue Resident 40's hydroxyzine despite an order from the physician to discontinue if it was not being used. The DON stated the MAR indicated this resident has not used any doses of hydroxyzine since August 2024 as it seems that the resident's itching is adequately controlled with the Benadryl. The DON stated there is a risk of increased side effects, such as sedation, if both Benadryl and hydroxyzine are used together which could negatively impact Resident 40's quality of life. The DON stated, because of the risk of adverse effects and non-use, the hydroxyzine should have been discontinued in August per the physician's order. A review of the facility's policy Medication Therapy, revised April 2007, indicted Each resident's medication regimen shall include only those medication necessary to treat existing conditions and address significant risks . all medication orders will be supported by appropriate care process and practices .the physician will identify situations where medications should be tapered, discontinued, or changed to another medication, for example . when a medication is being given . in the absence of a valid clinical rationale .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 40994 Based on interview and record review, the facility failed to perform a gradual dose reduction (GDR - a periodic attempt to manage a resident's behavioral issues with a lower dose of medication) related to the use of Depakene solution (a medication used to treat mood swings) or document a clinical rationale as to why an attempt would be contraindicated in one of five sampled residents (Resident 65.) The deficient practice of failing to perform or consider an GDR increased the risk Resident 65 could have experienced adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to Depakene therapy possibly leading to impairment or decline in their mental or physical condition or functional or psychosocial status. Findings: During a review of Resident 65's Admission Record (a document containing diagnostic and demographic information), dated 10/8/24, indicated she was admitted to the facility on [DATE] with diagnoses including bipolar disorder (a mental illness characterized by mood swings from manic highs to depressive lows.) During a review of Resident 65's History and Physical (H&P - a record of a comprehensive physician's assessment), dated 4/15/24, confirmed this resident's diagnosis of bipolar disorder. During a review of Resident 65's Order Summary Report (a summary of all currently active physician orders), dated 10/8/24, indicated on 8/22/22, Resident 65 was prescribed Depakene 250 milligrams (mg - a unit of measure for mass) per 5 milliliters (ml - a unit of measure for volume) to take 10 ml by mouth one time a day for bipolar disorder manifested by yelling/screaming. During a review of the consultant pharmacist's recommendation, dated 8/3/24, indicated the consultant pharmacist asked the physician to consider reducing the dose of Resident 65's Depakene solution or to indicate a clinical rationale as to why an attempt would be clinically contraindicated. During a review of Resident 65's clinical record, no documentation was found indicating the physician responded to the consultant pharmacist's request to consider a GDR for Depakene solution or any other indication the dose of Depakene has changed since August 2022. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/08/24 at 10:03 AM, the Director of Nursing (DON) stated the facility failed to ensure the physician responded to the consultant pharmacist's request to decrease the dose of Depakene for Resident 65. The DON stated the GDR request addressed two different medications, but the GDR was only performed on one of them. The DON stated there is no record of a specific response to the pharmacist's request or any other record that addresses the dosage of Depakene specifically and the resident has been on the same dose since August of 2022. The DON stated the facility failed to decrease the dose or document a dosage reduction would be contraindicated for resident-specific reasons. The DON stated the failure to consider a GDR or respond to the pharmacist's request for GDR increased the risk that Resident 65 may have experienced adverse effects of Depakene, such as increased sedation, due to using a higher dose than necessary which could have negatively impacted her quality of life. During a review of the facility's policy Tapering Medication and Gradual Drug Dose Reduction , revised April 2007, indicated The physician will review periodically whether current medication are still necessary in their current doses; for example, whether an individual's conditions or risk factors are sufficiently prominent or enduring that they require medication therapy to continue in the current dose, or whether those conditions and risks could potentially be equally well managed or controlled without certain medication, or with a lower dose . The physician will order appropriate tapering of medication, as indicated .

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 38740 Based on observation, interview and record review, the facility failed to ensure kitchen staff were routinely trained and evaluated for competency related to their duties when: 1.Dietary Aid (DA2) and Dishwasher (DW) did not know the concentration strength of the chlorine sanitizer used in the dish machine (chlorine sanitizer a product that is used to reduce or eliminate pathogenic agents on surfaces). 2. Cook1 did not follow standardized recipes when preparing pureed diet and did not prepare enough zesty meat sauce to meet facility residents need. These deficient practices had the potential to result in unsafe and unsanitary food production that could place 109 residents in the facility who received food at risk for foodborne illness and 16 residents who received lumpy pureed spaghetti at risk for choking and meal dissatisfaction in 12 residents who did not receive the spaghetti and meat sauce. Findings: 1.During an observation in the dishwashing area on 10/6/2024 at 9:45AM, Dishwasher (DW) was wearing gloves and rinsing the dirty dishes then loading them inside the dishwasher. When asked about the sanitizer, DW attempted to test the sanitizer concentration in the dish machine. DW removed one dirty glove and kept the other then proceeded to take the test strip from its container and check the sanitizer effectiveness on the clean and sanitized dish surfaces. During the same observation and interview with DW and Dietary Aide (DA2) on 10/6/2024 at 9:50AM, DW emersed the test strip on the dish surface with dirty gloves on, then compared to the color chart for chlorine sanitizer range. When asked DW stated the acceptable range for chlorine sanitizer is 200PPM. DW stated the test strip is not showing 200PPM, it is showing 50PPM. During the same observation and interview DA2 who was standing next to DW, DA2 stated the acceptable range for chlorine sanitizer is 200PM, then stated maybe its 120PPM. During a review of in-service records and interview with Dietary Supervisor (DS) on 10/06/2024 at 10:00AM DS stated the acceptable range for chlorine sanitizer is between 50-100PPM, DS stated staff was provided in service regarding sanitizers but both DW and DA2 were absent during the in-service day. DS stated DW and DA2 are confused between the two different sanitizers chlorine and quaternary sanitizer (quat, a type of sanitizing solution) used in the kitchen. DS sated they need to know the acceptable range so they can inform supervisor if something is wrong. A review of Food and Nutrition Services in -service dated 9/23/24 on dish machine-chlorine level/temperature indicated DA2 and DW were not present for the in service. A review of facility policy titled Dish washing (dated 2018) indicated, The chlorine should read 50-100PPM on dish surface final rinse. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility policy titled Sanitation (dated 2018) indicated, The Food service director is responsible for instructing Food and Nutrition Services personnel in the use of equipment. Each employee shall know how to operate and clean all equipment in his specific work area . 2. During an observation and a concurrent interview with Cook1 on 10/6/2024 at 1:05PM, the pureed spaghetti was not smooth and was chunky. The zesty meat sauce was not enough for all the residents. Cook1 stated he was rushing and did not add enough liquid to blend the spaghetti until the mixture was smooth. Cook1 stated he added water but should have added more water. During the same interview, cook1 stated he didn't realize some residents are now double portion and he miscalculated the amount of meat to cook. Cook1 stated he did not notify DS when he ran out of the meat sauce to provide comparable alternatives. During an interview with DS on 10/6/2024 at 1:05PM, DS stated cooks should notify DS and Registered Dietitian when there is an issue during food production and service. DS stated not receiving the food on the menu can cause meal dissatisfaction and residents can be upset. During a review of the facility recipe for the Spaghetti with zesty meat sauce, it indicated puree the pasta and use milk for liquid. A review of cook's job description (dated 2018), indicated, Duties and responsibilities: attend menu conference and plan food quantities to meet serving needs of the residents, report to food service director any problems with staff, food needs or any other irregularities.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 38740 Based on observation, interview and record review, the facility failed to ensure the standardized recipes for lunch menu was followed on 10/6/2024 when: 1.Facility failed to ensure 16 residents on puree diet (The pureed diet provides foods that do not require chewing and are easily swallowed. All foods should be smooth and pureed to the consistency of pudding.) received spaghetti texture in form that meet their needs when the texture of the puree spaghetti was lumpy, not smooth and had large pieces of pasta present requiring chewing before swallowing. 2.The facility failed to follow lunch menu and portion sizes as written for residents on pureed diet. 16 residents on pureed diet received 1/2 cup of pureed meat sauce instead of 2/3 of cup per the food portion and serving guide. Residents on pureed diet did not receive the pureed garlic bread per the menu. These deficient practices had the potential to result in meal dissatisfaction, decreased nutritional intake, wight loss and increased choking risk for 16 residents who were on puree diet. Findings: 1.During an observation of the tray line service for lunch on 10/06/2024 at 11:45AM, the pureed spaghetti looked dry and not smooth. During the serving of the pureed spaghetti observed pieces of pasta on the plate. During an interview and taste test of the pureed spaghetti with DS and Registered Dietitian (RD) on 10/06/2024 at 12:45PM, the pureed spaghetti was thick with lumpy texture. The pureed spaghetti had pieces of noodles resembling rice. There were chunky pieces of pasta that required chewing and moving around in the mouth before swallowing. DS stated the consistency of the pureed spaghetti is chunky and there are pieces of the noodles requiring chewing before swallowing. DS stated pureed diet should not require chewing. RD stated the texture of the pureed spaghetti is not smooth. During an interview with cook1 on 10/06/2024 at 1:05PM, cook1 stated the spaghetti is not smooth. Cook1 stated he should blend the spaghetti longer and add more broth for a smooth consistency. Cook1 stated he was rushing, and he did not prepare the pureed spaghetti correctly. Cook1 stated it is important for the pureed food to be smooth because it can cause choking in residents. A review of the facility policy titled IDDSI pureed (dated 2018) indicated, this diet is usually eaten with a spoon, does not require chewing and falls off a spoon in a single spoonful when tilted and continues to hold shape on a plate, does not have any lumps, is not sticky. 2.According to the facility lunch menu for pureed diet on 10/06/2024, the following items will be served: Wheat spaghetti pureed 1/2 cup; zesty meat sauce pureed #6 scoop (2/3 cup); cauliflower and peas pureed 1/3 cup; garlic bread 1 slice pureed; ice cream and milk. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of the tray line service for lunch on 10/06/2024, at 11:45AM, residents who were on puree diet the cook served pureed zesty meat sauce using #8 scoop yielding 1/2 cup instead of 2/3 cup per menu. During the same lunch service observation, the residents on pureed diet did not receive pureed garlic bread with their lunch per menu. During a review of the menu and interview with cook1 and DS on 10/06/2024 at 1:05PM, cook1 stated he served the wrong scoop and served less meat sauce to residents who were on pureed diet. Cook1 stated he forgot to prepare the pureed garlic bread. Cook1 stated its important to make sure the correct amount is served because serving less food residents can lose weight. DS stated it is important for cooks to follow the menu and the spreadsheet (food portion and serving guide) so residents can receive the correct portion and meet their nutrition needs. During the same interview RD stated she will provide in-service on portion sizes, food textures and following the menu. A review of facility menu and spreadsheet (portion and serving guide) on 10/07/2024 indicated serve 2/3 cup of pureed zesty meat sauce and 1 slice of pureed garlic bread. A review of facility policy titled Menu Planning (dated 2018) indicated, The menus are planned to meet nutritional needs of residents in accordance with established national guidelines, physicians' orders and . most recent recommended dietary allowances .the menus provide a variety of foods in adequate amount each meal.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38740 Based on observation, interview and record review, the facility failed to ensure safe and sanitary food storage and preparation practices when: 1. There was no soap available in the handwashing sink. 2. One plastic bag of sliced raw meat, and two logs of ground beef thawing on the rack with no thaw date. One open container of cottage cheese and one container of juice with no open date and previously prepared house shake stored in a large one-gallon milk container. 3. Food brought to residents from outside of the facility, were stored in the resident food refrigerator with no use by date. There were four tv dinners with manufactures instruction to store frozen was stored in the refrigerator with no use by date. These deficiencies had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to food borne illness in 109 out of 111 residents who receive food from facility, including 28 residents who received house shake and residents who had food stored in the resident refrigerator. Findings: 1.During an observation in the kitchen on [DATE] at 8:40AM one cook (Cook1) was washing hands in the handwashing sink, there was no soap and cook1 proceeded to wash and dry hands with paper towel. During the same observation there was no soap for surveyor to wash hands. During a concurrent interview, cook1 stated there is no soap, cook1 stated he does not know when the soap was finished. Cook1 stated he informed housekeeping to bring the soap. Cook1 then left the kitchen. During the same observation and interview with dietary supervisor (DS) on [DATE] at 8:40AM DS stated I informed the house keeping staff to bring soap. DS stated it is important to have soap for handwashing to prevent germ from contaminating hands, infection control and food borne illness. During an observation on [DATE] at 8:50AM housekeeping staff replaced the soap dispenser. A review of facility policy titled Hand washing procedure (dated 2018), indicated, Hand washing is important to prevent the spread of infection, use warm running water and soap, preferably from a dispenser .special considerations: soap and paper towel must be readily available. 2. During an observation in the kitchen on [DATE] at 9:00AM, there was one medium size plastic bag with soft and thawed raw sliced beef with date of [DATE] and two large logs of raw ground beef that were still frozen with receive date of [DATE]. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on [DATE] at 9:00AM, DS stated DS is not sure when the sliced beef was pull out of the freezer to thaw. DS stated DS is not sure because the date does not indicated thaw or use by date. DS removed the beef from the walk-in refrigerator to discard. DS stated the ground beef logs were pulled out of the freezer this morning and will be cooked for lunch. DS stated there should be a thaw date to make sure food is adequately cooked or discarded. During an observation and interview with DS in the kitchen on [DATE] at 9:10AM, there was one box of prune juice with no open date and one gallon of milk bottle with a brown color beverage labeled shake with a preparation date of [DATE] was stored in the reach in refrigerator (refrigerator #2). DS stated prune juice should have an open date to know when to discard expired items. DS stated the shake stored in the milk gallon is a high calorie beverage prepared in the kitchen. DS stated staff should not store the house shake inside the milk gallon because there is risk of contamination. DS stated DS does not know if the gallon of the milk was cleaned to store the shake. During a concurrent observation and interview with Dietary Aide (DA1) on [DATE] at 9:15AM, DA1 stated the house shake is prepared by mixing milk with other ingredients. DA1 stated the mixture of house shakes is stored in a clean pitcher and should not be refilled in the milk gallon. DA1 stated using an empty milk gallon can cause cross contamination of the shake. During a concurrent observation and interview with DS on [DATE] at 9:20AM there was one open container of cottage cheese that was more than half full with dates [DATE]-[DATE] and no open date stored in the reach in refrigerator (refrigerator #1). DS stated the cottage cheese is stored for 3 days, DS stated the container is labeled wrong and removed the container to discard. DS stated items should be dated so they are discarded when expired. A review of facility policy titled Procedure for Refrigerated Storage (dated 2018) indicated, Frozen food should be left in the refrigerator to thaw. Once thawed, uncooked meat is to be used within 2 days. Leftovers will be covered labeled and dated. A review of facility policy titled Food Preparation (dated 2018) indicated, Label defrosting meat with pull and use by date. A review of facility Refrigerated storage guide (dated 2018) indicated for cottage cheese follow expiration date or 7 days after opening whichever comes first. 3. During an observation in the resident refrigerator located in the conference room on [DATE] at 09:50AM. The thermometer inside the refrigerator read 39 degrees Fahrenheit. There were two plastic containers of leftover food labeled with resident name and date of [DATE] stored in the refrigerator. During the same observation there was another bag with four TV dinners with manufacture instruction to keep frozen were stored in the refrigerator with a date of [DATE]. During a concurrent observation and interview with DS on [DATE] at 10:00AM, DS stated the food is not labeled with the use by date per policy and should be discarded. DS stated the tv dinners should be stored frozen in the freezer per manufactures guidance and should be discarded because it was not stored safely. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility policy titled Foods Brought by family/Visitors (revised February 2018) indicated, Perishable foods must be stored in a resealable container with tightly fitting lids in a refrigerator. Containers will be labeled with the resident's name, the item and the use by date. The nursing staff will discard perishable foods on or before the use by date.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415 Based on interview and record review, the facility failed to assess the mental capacity (ability to make decisions) of one of three sampled residents (Resident 65) to sign a legaly binding document before indicating the Arbitration agreement (a contract indicating any disputes would be resolved within the facility rather than in court) was signed by Resident 65. This failure had the potential to result in Resident 65 not fully understanding their rights, to limit opportunity to initiate judicial proceedings that challenge unfavorable decisions. During a review of Resident 65's Admission Record, the Admission Record indicated, Resident 65 was admitted to the facility on [DATE] with diagnoses including unspecified sequalae (condition resulting from a prior disease or injury) of cerebral infarction (a loss of blood flow to part of the brain), bipolar disorder (mental disorder that causes extreme shifts in mood, energy, and activity levels), anxiety disorder (uncontrollable feelings of fear and anxiety), and dementia (a progressive state of decline in mental abilities). During a review of Resident 65's Minimum Data Set [(MDS) a Federally mandated assessment tool], dated 8/12/2024, the MDS indicated Resident 65's cognitive skills (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) were moderately impaired. The MDS indicated Resident 65 was dependent on toilet transfer, chair/bed to chair transfer, and bathing, required maximal assistance for oral and toilet hygiene, and required moderate assistance in personal hygiene. The MDS indicated Resident 65 utilized a wheelchair for mobility and does not have impairments on both the upper and lower extremities (arms and legs). During a review of Resident 65's History and Physical (H&P), dated 3/14/2022, the H&P indicated, Resident 66 does not have the capacity to understand and make decisions for herself. During a review of Resident 65's Arbitration Agreement dated 1/13/2023, the Arbitration Agreement indicated Resident 65 had officially signed the agreement. During a concurrent interview and record review on 10/8/2024 at 2:15p.m., with Resident 65, Resident 65 stated she does not recall getting informed about the Arbitration Agreement and does not recognize her signature. During an interview on 10/8/2024 at 2:33p.m., with Resident 65's family, Resident 65's family member stated she does not recall being informed regarding an Arbitration Agreement and confirmed Resident 65 cannot sign for herself ever since she had had a stroke (loss of blood flow to a part of the brain). (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/8/2024 at 2:49 p.m., with the Admissions Assistant (AA), the AA stated Arbitration Agreements are voluntary and a part of the admission packet. The AA stated she is not sure if Resident 65 was able to decide whether to sign the Arbitration Agreement or not. The AA stated a facility staff (unknown) signed the document and indicated it was Resident 65's signature. The AA stated if a resident does not have the capacity to sign a legal document, she will contact the Residents legal representative (family member, power of attorney), explain the Arbitration Agreement, and let the representative decide whether to sign the document or not. The AA stated in Resident 65's case, she would have to ask the family member to review the Arbitration Agreement again and obtain a new agreement and will always check whether the resident is alert and oriented. During a review of the facility's Arbitration Agreement, undated, the agreement indicated by signing this arbitration agreement below, the parties agree ot be bound by the provisions of this Arbitration Agreement. Further the Resident (or Resident's Legal Representative and/or Agent on behalf of Resident) acknowledges that: (A) the agreement has been explained to the Resident (or Resident's Legal Representative and/or Agent on behalf of Resident) by a representative of the Facility in the form and manner that the Resident understands, including the language .and (B) the Resident (or Resident's Legal Representative or Agent on behalf of Resident) understands this agreement.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415 Based on interview and record review, the facility failed to implement the antibiotic stewardship program policy for four of five sampled residents (Resident 39,96, 37 and 42) when an antibiotic (a substance used to kill bacteria and to treat infections) did not meet McGeer Criteria (criteria used to determine appropriate use of antibiotics) for administration. This deficient practice had the potential to increase antibiotic resistance and provide antibiotics to the residents without justification. 1.During a review of Resident 39's Admission record, the Admission Record indicated Resident 39 was admitted to the facility on [DATE] with diagnoses including Parkinsonism (condition that affects movement), Bullous Pemphigoid (rare skin disorder that causes large fluid filled blisters on the skin), and Type II Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 39's Minimum Data Set [(MDS) a Federally mandated assessment tool], dated 8/20/2024, the MDS indicated Resident 39's cognitive skills (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) were mildly impaired. The MDS indicated Resident 39 required maximal assistance in toilet transfer, chair/bed-to-chair transfer, oral hygiene, dressing the upper and lower body, bathing, and required moderate assistance for oral and personal hygiene. The MDS indicated Resident 39 did have an impairment on one side of the upper extremities (arms/shoulders) and did not have any impairments on both of the lower extremities (arms and legs) and utilized a walker and a wheelchair. During a review of the McGeer's Criteria for Infection Control Surveillance (a document to identify whether the symptoms meet the criteria for definitive infection) dated 5/18/2024, the McGeer's criteria indicated Resident 39 had skin, soft tissue, and mucosal infections, cellulitis (bacterial skin infection that spreads rapidly), soft tissue, or wound infection. The surveillance document did not indicate an onset date and the section for indicating new or increasing presence of at least four (4) of the following sign or symptom of an infection, sub criteria indicated 'heat' at the affected site. Resident 39 was prescribed Doxycycline (an antibiotic) 100 milligram (mg: unit of mass) tablet by mouth. Resident 39 was admitted from the hospital with an order of Doxycycline 100mg for Bullous Pemphigoid. During a review of the McGeer's Criteria for Infection Control Surveillance for Resident 39, dated 7/30/2024, the surveillance documents indicated the McGeer's criteria indicated (Resident 39 had a) urinary tract infections (UTI: infection in the urinary system) and no other sub criteria (signs and symptoms of a UTI infection) were selected. Resident 39 was ordered an antibiotic to treat the UTI called Amikacin Sulfate Injection Solution (Amikacin Sulfate: used to treat severe or serious bacterial infections) 250mg Intravenous (IV: device inserted into vein to provide medication or fluid) in the evening for UTI for seven (7) days. (continued on next page)

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	056164	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Palms Healthcare	1020 Termino Avenue Long Beach, CA 90804

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review of Resident 39's McGeer's Criteria form on 10/8/2024 at 4:08p.m. with Infection Preventionist Nurse (IPN), the IPN stated the antibiotic stewardship is a process to minimize the increase of infections, minimize the use of antibiotic to prevent antibiotic resistance, and ensure residents are not on antibiotics unnecessarily. The IPN stated the McGeer's Criteria is a tool that is used to determine whether the resident has a true infection or not and or whether the resident qualifies to receive antibiotics. The IPN stated Resident 39 is currently on Doxycycline 100 mg three times a day for Bullous Pemphigoid, the IPN indicated the dermatologist (medical doctor who treats and diagnose skin disorders) would like to do laboratory tests (medical tests usually done on the resident's blood) every month until 11/12/2024 and decide whether to discontinue the antibiotics or not on 11/24/2024. The IPN stated Resident 39 has been on Doxycycline since admission on 5/17/2024. The IPN stated the McGeer's Criteria documentation dated 5/18/2024 for the skin infection did not meet the criteria for the use of antibiotics because only one out of four indicated subcriteria were met. The IPN stated the McGeer's Criteria documentation dated 7/30/2024 for the UTI did not indicate any sub criteria were met to justify use of antibiotics. 2. During a review of Resident 96's Admission Record, the Admission Record indicated Resident 96 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including UTI, infection and inflammatory reaction due to indwelling urethral catheter (thin tube inserted into the bladder to drain urine), and extended spectrum beta lactamase (ESBL: enzyme produced by bacteria that are resistant to common antibiotics) resistance. During a review of Resident 96's MDS dated [DATE], the MDS indicated Resident 96's cognitive skills were intact. The MDS indicated Resident 96 is dependent on toilet hygiene, bathing toilet transfer, required maximal assistance dressing the lower body and required moderate assistance for oral hygiene, personal hygiene, and upper body dressing. The MDS indicated Resident 96 had impairments the lower extremities bilaterally and utilized a wheelchair and walker for mobility. During a review of Resident 96's McGeer's Criteria for Infection Control Surveillance dated 9/24/2024, the McGeer's criteria indicated Resident 96 had a urinary tract infection without an indwelling catheter. The McGeer's Criteria indicated both criteria one (1) and two (2) must be present with at least one of the following sign or symptom subcriteria, but there were no sub criteria's indicated on the surveillance form. Resident 96 came from the hospital with an order to continue the antibiotic Cephalexin (generic name: Keflex) (medication is used to treat a wide variety of bacterial infections) 500mg for UTI due to the presence of Escherichia coli (E. Coli: bacteria found in food, water, and intestines) and ESBL taken from the catheter. During a concurrent interview and record review on 10/8/2024 at 4:28 p.m., of Resident 96's McGeer's Criteria dated 9/27/2024 on with the IPN, the IPN stated the sub criteria: in the absence of fever or leukocytosis (a blood test result indicating infection), then two (2) or more of the sub criteria indicating infection should have been selected. The IPN stated Resident 96 was on the Cephalexin from 9/26/2024 to 10/6/2024. 3. During a review of Resident 37's Admission Record, the Admission Record indicated Resident 37 was admitted to the facility on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (partial weakness on one side of the body) affecting right dominant side, hypertension (high blood pressure), and anxiety (excessive worry, fear) disorder. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 37's MDS dated [DATE], the MDS indicated Resident 37's cognitive skills were intact. The MDS indicated Resident 37 required maximal assistance for chair/bed to chair transfer, toilet transfer, bathing, toilet hygiene, and required moderate assistance for personal hygiene, oral hygiene, and dressing the upper and lower body. The MDS indicated Resident 37 did not have any impairments on both the upper and lower extremity and utilized a wheelchair and walker. During a review of the McGeer's Criteria for Infection Control Surveillance dated 9/29/2024, the McGeer's criteria indicated Resident 37 had skin, soft tissue, and mucosal infections, cellulitis (bacterial skin infection that spreads rapidly), soft tissue, or wound infection. The onset date was 9/27/2024 and the section indicating new or increasing presence of at least four (4) signs or symptoms of infection, the surveillance documents indicated only two of the required four subcriteria were selected. Resident 37 was prescribed Bactrim double strength (DS) (used to treat various bacterial infections) oral tablet 800-160mg for 10 days for folliculitis (inflamed hair follicle due to infection) and redness on the nose to forehead. During a concurrent interview and record review of Resident 37's McGeer's Criteria on 9/27/2024 at 4:39 p.m. , with the IPN, the IPN stated the use of antibiotics to treat folliculitis did not meet the McGeer's criteria since only two of four subcriteria were selected. 4. During a review of Resident 42's Admission Record, the Admission Record indicated Resident 42 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including pneumonia (infection in one or both of the lungs), UTI, and dysphagia (difficulty swallowing). During a review of Resident 42's MDS dated [DATE], the MDS indicated Resident 42's cognitive skills were moderately impaired. The MDS indicated Resident 42 required maximal assistance for most of the activities of daily living (ADL: bathing, chair/bed-to-chair transfer, oral hygiene) and required moderate assistance in dressing the upper body and eating. The MDS indicated Resident 42 did not have any impairments for both the upper and lower extremities and utilized a wheelchair. During a review of Resident 42's McGeer's Criteria for Infection Control Surveillance dated 7/31/2024, the McGeer's criteria indicated Resident 42 had a respiratory tract infection. The Surveillance form did not indicate any sub critera to justify administering antibiotics. Resident 42 was prescribed Ceftriaxone (used to treat bacterial infections in many different parts of the body) Sodium Intravenous Solution Reconstituted (process of adding a liquid to a dry ingredient to make a specific concentration of liquid) 1gm intravenously every 24 hours for bronchitis (inflammation in the airway of the lungs) for seven days. During a concurrent interview and record review of Resident 42's McGeer's Criteria on 7/31/2024 at 4:47p.m. with the IPN, the IPN stated there are no subcriteria selected, tIPN stated the subcriteria can identify the type of infection the resident has and the treatment can change depending on the infection. IPN stated Resident 42 ended her antibiotics on 8/6/2024 and does not know whether her symptoms have cleared up at that time. IPN stated she would know if an antibiotic was effective if the resident does not show anymore signs and symptoms (s/s) of the infection but reiterated she has not documented any notes post antibiotic use. IPN stated following up can determine whether the antibiotics were effective or not since without a follow up, the resident may still have an infection and would be monitored from the moment they start until they finish the antibiotic. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Antibiotic Stewardship-Orders for Antibiotics, revised 12/2016, the P&P indicated antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program and in conjunction with the facility's general policy for medication Utilization and Prescribing. Appropriate indications for use of antibiotics include criteria met for clinical definition of active infection or suspected sepsis .the staff and practitioner will document the specific criteria that support the suspicion in the resident's clinical record.