STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056176	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Heights Transitional Care Center	2707 Pine Street San Francisco, CA 94115

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 36105 Based on interview, record review, and facility policy review, the facility failed to notify the physician when medications were not available for administration to 1 (Resident #38) of 1 resident reviewed for notification of change and 2 (Resident #308 and Resident #96) of 5 residents reviewed for unnecessary medications. Findings included: A facility policy titled, Change in a Resident's Condition or Status, revised in 05/2017, specified, 1. The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): e. need to alter the resident's medical treatment significantly. 1. An Admission Record revealed the facility admitted Resident #38 on 07/18/2024. According to the Admission Record, the resident had a medical history that included diagnoses of hypertensive heart disease with heart failure and hyperlipidemia (elevated cholesterol level). An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/24/2024, revealed Resident #38 had a BIMS score of 15, which indicated the resident had intact cognition. Resident #38's care plan included a focus area, initiated on 07/21/2024, that indicated the resident was at risk for cardiac distress related to atrial fibrillation, congestive heart failure, hyperlipidemia, and hypertension (high blood pressure). An intervention initiated on 07/21/2024 directed staff to administer prescribed medication. Resident #38's Order Summary Report for the timeframe from 07/18/2024 through 08/28/2024 contained a physician's order, dated 07/18/2024, for losartan potassium tablet 100 milligrams (mg), one time per day for hypertension. The Order Summary Report also contained an order, dated 07/18/2024, for atorvastatin calcium tablet 20 mg, one tablet in the evening for hyperlipidemia. Resident #38's August 2024 Medication Administration Record (MAR) revealed losartan potassium was scheduled to be administered daily at 9:00 AM. The MAR revealed Licensed Vocational Nurse (LVN) #1 documented 9, which indicated Other/See Progress Notes, for the scheduled doses on 08/11/2024, 08/19/2024, 08/20/2024, 08/21/2024, 08/26/2024, and 08/27/2024. The MAR also revealed that Registered Nurse (RN) #2 documented 9 for losartan potassium on 08/23/2024 and 08/24/2024. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #38's Progress Notes, dated 08/11/2024 at 11:18 AM, 08/19/2024 at 10:36 AM, 08/20/2024 at 11:51 AM, 08/21/2024 at 10:31 AM, and 08/26/2028 at 10:53 AM, revealed LVN #1 documented the resident's losartan was pending. Progress Notes dated 08/23/2024 at 9:11 AM and 08/24/2024 at 8:56 AM revealed RN #2 documented that losartan was on order. The Progress Notes revealed no documented evidence Resident #38's physician was notified that the resident's medication was not available and was not administered to the resident. Resident #38's August 2024 MAR revealed atorvastatin was scheduled to administered daily at 5:00 PM. The MAR revealed RN #4 documented 9 for the scheduled doses on 08/19/2024, 08/20/2024, 08/26/2024, and 08/27/2024. The MAR also revealed RN #3 documented 9 on 08/21/2024, 08/22/2024, 08/23/2024, and 08/24/2024. Resident #38's Progress Notes dated 08/19/2024 at 5:49 PM, 08/20/2024 at 5:21 PM, 08/21/2024 at 9:51 PM, 08/22/2024 at 10:10 PM, 08/23/2024 at 8:27 PM, 08/24/2024 at 7:02 PM, and 08/26/2024 at 5:23 PM, revealed staff documented Resident #38's atorvastatin medication was on order, pending pharmacy delivery, or waiting for delivery. During an observation of medication administration on 08/27/2024 at 8:57 AM, LVN #1 stated Resident #38's losartan was not available in the medication cart. During an interview on 08/28/2024 at 1:38 PM, LVN #1 stated chart code 9 Other/See Progress Notes documented on the MAR meant that the medication had not been administered and there was an associated progress note. LVN #1 stated pending in her progress notes meant they were waiting for a refill from the pharmacy. Per LVN #1, a chart code of 14 documented on the MAR indicated the physician was notified; however, LVN #1 stated she did not document code 14 for this resident. LVN #1 stated she should have notified the physician, and normally when a resident missed a dose, particularly for a blood pressure or heart medication, the physician should be notified. During an interview on 08/29/2024 at 1:35 PM, RN #3 stated she informed the physician the previous day about the missing atorvastatin. RN #3 stated she did not recall whether she called the physician on 08/21/2024, 08/22/2024, 08/23/2024, or 08/24/2024 when the medication was not available. She stated usually she documented if she called the physician. During an interview on 08/28/2024 at 1:48 PM, Unit Manager (UM) #6 stated if a resident's medications were not available, the nurses should notify the physician. She stated it was particularly important for residents to receive their blood pressure medication. UM #6 stated the nurse should document the situation and any calls to the physician in the progress notes. During an interview on 08/29/2024 at 1:46 PM, Physician #5 stated he expected a facility nurse to contact someone in the physician's group when a medication could not be given. He stated he was not aware Resident #38 had not received medications. Physician #5 stated generally that high blood pressure could lead to a stroke but stated Resident #38 was not at risk. During an interview on 08/29/2024 at 2:15 PM, the Director of Nursing Services (DNS) stated the nurses should always inform the physician if a medication was not available to administer. She stated a resident could have problems if their blood pressure was too high. She stated the physician should have been notified, and it should have been documented. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/29/2024 at 2:39 PM, the Administrator stated he expected the nurses to notify the physician when a medication was not available. 45555 2. An Admission Record indicated the facility admitted Resident #308 on 08/02/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of type two diabetes mellitus with hyperglycemia (high blood sugar). An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/08/2024, revealed Resident #308 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Per the MDS, the resident had received six insulin injections during the seven days prior to the assessment. The MDS revealed the physician had not changed the resident's insulin orders in the previous seven days. Resident #308's care plan included a focus area, initiated on 08/02/2024, that indicated the resident was at risk for hypoglycemia (low blood sugar) and hyperglycemia. An intervention initiated on 08/02/2024 directed staff to administer prescribed insulin as ordered. Resident #308's Order Recap [recapitulation] Report for the timeframe from 08/02/2024 through 08/28/2024 revealed an order, started on 08/07/2024, for Ozempic (used to improve blood sugar levels) 2 milligrams (mg) per 3 milliliters (ml), with instructions to inject 0.25 mg subcutaneously, once every seven days for diabetes mellitus. Resident #308's August 2024 Medication Administration Record (MAR) revealed Registered Nurse (RN) #2 documented a code 9, indicating Other/See Progress Note, for the resident's Ozempic each week it was due to be administered, on 08/07/2024, 08/14/2024, and 08/21/2024. Resident #308's Progress Notes revealed Orders-Administration Notes, dated 08/07/2024, 08/14/2024, and 08/21/2024, that indicated the resident's Ozempic was on order. There was no documentation the physician was notified that the medication was not administered. During an interview on 08/29/2024 at 11:26 AM, RN #2 stated that the mangers entered physician's orders and put a medication list in the physician's binder. She stated once medications came from the pharmacy, she checked to make sure all the ordered medications were delivered. She stated if the facility did not receive all the resident's medications, she notified the physician to let them know a medication was not available. However, RN #2 stated when Resident #308's Ozempic was not available the first week, she notified the manager, and the manager called the pharmacy. She stated when it was not available the second week, she notified the manager and documented on the order form. According to RN #2, when Resident #38's Ozempic was not available again the next week, the manager requested a high-cost form and received the medication. During an interview on 08/29/2024 at 12:32 PM, RN #8, who was the nurse manager for the floor where Resident #308 resided, stated she admitted new residents and sent their medication list to the pharmacy. She stated the next morning the charge nurse should report any missing medication and notify the physician. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/29/2024 at 1:46 PM, Physician #5 stated there were three other doctors and a nurse practitioner with their group, and he expected the facility nurse to contact someone in their group if a medication could not be given. Physician #5 indicated he was not aware Resident #308 had missed their medications and stated their practice should have been aware. During an interview on 08/29/2024 at 2:04 PM, the Director of Nursing Services (DNS) stated that when a medication was not available, the nurse should notify the physician that the medication was not available. During an interview on 08/29/2024 at 2:49 PM, the Administrator stated the physician should be notified if s medication was not available because the physician provided direction for resident care. 3. An Admission Record indicated the facility admitted Resident #96 on 07/05/2024. According to the Admission Record, the resident had a medical history that included diagnoses of acute on chronic diastolic congestive heart failure (CHF) and history of pulmonary embolism (blood clot in a lung). A 5-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/09/2024, revealed Resident #96 had a BIMS score of 00, which indicated the resident had severe cognitive impairment. The MDS indicated the resident had taken an anticoagulant medication in the seven days prior to the assessment. Resident #96's Order Recap [recapitulation] Report for the timeframe from 07/05/2024 through 08/28/2024, contained an order, dated 08/08/2024, for Eliquis (an anticoagulant) 5 milligrams (mg) with instructions to administer two tablets twice a day for blood clotting prevention until 08/14/2024. Resident #96's August 2024 Medication Administration Record (MAR) for Eliquis revealed Registered Nurse (RN) #7 documented a code 9, which indicated Other/See Progress Note, for the resident's medication administration on 08/11/2024 at 9:00 PM and on 08/12/2024 at 9:00 AM. Resident #96's Progress Notes revealed an Orders-Administration Note dated 08/11/2024 and 08/12/2024 that indicated the resident's Eliquis was pending delivery. During an interview on 08/29/2024 at 10:53 AM, RN #7 stated if a medication was not available during medication pass, she notified the physician. RN #7 stated she did not recall specifics regarding Resident #96's Eliquis. During an interview on 08/29/2024 at 1:47 PM, Physician #5 stated he expected the facility nurse to notify someone in his group when a medication was not available to be administered. He could not recall any specific medications not being available. During an interview on 08/29/2024 at 2:04 PM, the Director of Nursing Services (DNS) stated that when a medication was not available, the nurse should notify the physician that the medication was not available. During an interview on 08/29/2024 at 2:49 PM, the Administrator stated the physician should be notified if s medication was not available because the physician provided direction for resident care.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 35314 Based on observation, interview, and facility document and policy review, the facility failed to ensure each resident was provided a homelike environment, which affected 1 (Resident #55) of 2 residents reviewed for environmental concerns. Specifically, the facility failed to provide a window curtain upon Resident #55's request. Findings included: A facility policy titled, Quality of Life- Homelike Environment, revised 05/2017, revealed, Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The policy further revealed, 2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. Clean, sanitary and orderly environment; b. Comfortable (minimum glare) yet adequate (suitable to the task) lighting. c. Inviting colors and decor. An Admission Record revealed the facility admitted Resident #55 on 05/27/2021. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/30/2024, revealed Resident #55 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. During a concurrent interview and observation on 08/26/24 11:27 AM, Resident #55 stated they had requested for several months that the facility staff install an additional window curtain in their room. An observation revealed the resident's room had one curtain that did not fully cover the window. During an interview on 08/27/2024 at 9:29 AM, the Environmental Services (EVS) Manager stated each floor of the facility had a work order binder for work orders to go in, and the binders were checked twice per day. A Work Orders LOG, for the timeframe from 07/01/2024 through 07/31/2024, revealed a work order, dated 07/26/2024, requesting an additional curtain for the window in Resident #55's room. The log indicated that the priority was categorized as ASAP [as soon as possible]. The log did not reflect a completion date for the work order but had an undated note that indicated blinds were ordered. A Work Orders LOG, for the timeframe from 08/02/2024 through 08/28/2024, revealed no work orders for Resident #55's room. During an interview on 08/28/2024 at 10:13 AM, the EVS Manager stated there had been no replacement curtains or blinds ordered until 08/28/2024. During interview on 08/29/2024 at 11:12 AM, the Administrator said residents should be able to close their curtains fully.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 37935 Based on record review, interview, facility policy review, and review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to ensure the accuracy of a Minimum Data Set (MDS) assessment for 1 (Resident #2) of 5 residents reviewed for unnecessary medications. Specifically, the facility failed to code Resident #2's MDS assessment to reflect the use of an anticoagulant. Findings included: The Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2023, indicated, N0415E1. Anticoagulant (e.g. [exempli gratia, for example], warfarin, heparin, or low-molecular weight heparin): Check if an anticoagulant medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days. N0415E2. Anticoagulant: Check if there is an indication noted for all anticoagulant medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days). A facility policy titled, RESIDENT ASSESSMENT INSTRUMENT, dated 10/01/2023, indicated Section N Medications was to be completed by MDS staff. The policy revealed, Each discipline assigned to complete the designated section of the MDS assessment is responsible for the accuracy of the information following the RAI manual. An Admission Record indicated the facility admitted Resident #2 on 06/29/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of other pulmonary embolism (a blood clot in an artery of a lung). Resident #2's care plan revealed a focus area, initiated on 06/29/2024, that indicated Resident #2 was at high risk for signs and symptoms of bruising and bleeding due to being on anticoagulant therapy to prevent thrombosis or embolism. Resident #2's Order Summary Report, listing active orders as of 08/28/2024, contained an order, started on 06/30/2024, for apixaban (an anticoagulant) oral tablet 2.5 milligrams (mg), one tablet by mouth two times a day for blood thinner. Resident #2's Medication Administration Record, for the timeframe from 06/01/2024 through 06/30/2024, revealed staff documented that the resident received apixaban 2.5 mg two times on 06/30/2024. Resident #2's Medication Administration Record, for the timeframe from 07/01/2024 through 07/31/2024, revealed staff documented that the resident received apixaban 2.5 mg during five of six opportunities from 07/01/2024 through 07/03/2024. An admission MDS, with an Assessment Reference Date (ARD) of 07/03/2024, was not coded to reflect Resident #2 was taking an anticoagulant medication. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/29/2024 at 10:51 AM, the Long-Term Care (LTC) MDS Coordinator stated they had two MDS staff, one for short-term care residents and one for long-term care residents. She stated that when a resident was admitted , the facility staff received an email and information from the hospital. The LTC MDS Coordinator stated she completed Section N of the MDS assessments. Per the LTC MDS Coordinator, she used doctor's orders to complete Section N. She stated that the other MDS Coordinator completed Resident #2's MDS assessment. She stated Resident #2's MDS assessment was coded to indicate the resident was not on anticoagulant medication. The LTC MDS Coordinator reviewed the resident's MARs and stated the MDS should have been coded to indicate the resident was receiving an anticoagulant medication. She stated it was missed and coded incorrectly. During an interview on 08/29/2024 at 11:05 AM, the Director of Nursing Services (DNS) stated she was not very involved with the MDS process and did not do a final review of MDS assessments. She stated that she expected MDS assessments to be coded accurately, including medications. During an interview on 08/29/2024 at 11:24 AM, the Administrator stated he was not involved with the MDS process at all. He stated that he expected MDS assessments to be coded accurately.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 35314 Based on interview, record review, facility policy review, and review of the California Department of Health Care Services Preadmission Screening and Resident Review (PASRR) Level I Assessment Guide, the facility failed to ensure a Level I PASRR was accurately completed for 1 (Resident #4) of 1 resident reviewed for PASRR requirements. Specifically, the facility failed to ensure Resident #4's Level I PASRR Screening reflected the presence of a serious diagnosed mental disorder. Findings included: A facility policy titled, Preadmission Screening & Resident Review (PASRR), dated 11/30/2023, revealed, 1. Initial admission from General Acute Care Hospital: a. General Acute Care Hospitals (GACHs) located in California are enrolled and utilizing the Department of Health Care Services' (DHCS') PASRR Online System to complete the PASRR process prior to discharging an individual to a SNF [skilled nursing facility], regardless of payer source. b. Facility will: i. Confirm that the PASRR process was completed by the Hospital (including admission from the Emergency Department) by accepting and reviewing the PASRR documentation submitted by the Hospital via the file exchange feature in the PASRR Online System. The California Department of Health Care Services Preadmission Screening and Resident Review (PASRR) Level I Assessment Guide, dated 01/12/2023, revealed, Section III-Serious Mental Illness Questions 10-12 This section helps determine if the individual may have a serious mental illness and benefit from specialized services. Question 10. diagnosed Mental Illness *Does the individual have a serious diagnosed mental disorder such as Depressive Disorder, Anxiety Disorder, Panic Disorder, Schizophrenia/Schizoaffective Disorder, or symptoms of Psychosis, Delusions, and/or Mood Disturbance? *If 'yes', there will be a text box question [to] provide the type of mental illness. The guide further specified, Question 12. Psychotropic Medication *If 'yes' a text box will appear to list all the names of psychotropic medications for mental illness. An Admission Record revealed the facility admitted Resident #4 on 06/15/2024. According to the Admission Record, Resident #4 had a medical history that included a diagnosis of bipolar disorder. Resident #4's hospital discharge records, dated 06/14/2024, revealed Resident #4 had a diagnosis of bipolar disorder. The records revealed the resident's medication orders included an order for mirtazapine (an antidepressant) 15 milligrams (mg) at bedtime, with a start date of 05/27/2024. Resident #4's Medication Review Report, listing orders on or after 06/15/2024, contained an order, dated 06/15/2024, for mirtazapine oral tablet 15 mg, one tablet at bedtime for depression. Resident #4's care plan included a focus area, initiated on 06/15/2024, that indicated the resident had an alteration in their behavior pattern related to bipolar disorder. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/21/2024, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. According to the MDS, at the time of the assessment, the resident had an active diagnosis of bipolar disorder and was taking an antidepressant medication. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #4's Preadmission Screening and Resident Review (PASRR) Level I Screening, dated 06/15/2024, completed by a hospital, revealed Section III- Serious Mental Illness Screen, question #10 was answered No and did not reflect the resident's diagnosis of bipolar disorder. The screening also did not reflect that the resident was prescribed psychotropic medications for mental illness. This resulted in a Negative Level I Screening, and a Level II evaluation was not required. During an interview on 08/27/2024 at 1:33 PM, the Long-Term Care (LTC) MDS Coordinator stated medical records staff were responsible for reviewing Level I screenings upon admission. She stated that if the screening was not correct, she was responsible for completing a new resident review. She stated that she was not aware of any residents having an inaccurate Level I screening. During an interview 08/29/2024 at 8:56 AM, the Medical Records Director revealed she received the Level I screenings from the hospital. She stated that if there were any issues, she informed the LTC MDS Coordinator. She stated Resident #4 had been taking psychotropic medication and had a diagnosis of bipolar disorder. During an interview on 08/29/2024 at 9:14 AM, the Director of Nursing Services (DNS) revealed the admission team reviewed all residents' Level I screenings upon admission. She stated that if there were any issues with the screening, the LTC MDS Coordinator would submit an updated Level I screening. During an interview on 08/29/2024 at 11:17 AM, the Administrator stated that the MDS Coordinator was responsible for overseeing the Level I screening for each resident. He stated there should have been another Level I screening submitted for Resident #4 and stated that the facility staff missed it.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 45555 Based on interview, record review, and facility policy review, the facility failed to ensure the use of an anticoagulant medication was addressed in the comprehensive care plan for 1 (Resident #96) of 5 residents reviewed for unnecessary medications. Findings included: A facility policy titled, Care Plans, Comprehensive Person-Centered, revised 12/2016, revealed, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The policy revealed, 8. The comprehensive, person-centered care plan will: included g. Incorporate identified problem areas; and h. Incorporate risk factors associated with identified problems. The policy revealed, 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 14. The Interdisciplinary Team must review and update the care plan: including c. When the resident has been readmitted to the facility from a hospital stay. An Admission Record indicated the facility admitted Resident #96 on 07/05/2024. According to the Admission Record, the resident had a medical history that included diagnoses of acute on chronic diastolic (congestive) heart failure (CHF) and personal history of pulmonary embolism (a blood clot in an artery of a lung). An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/11/2024, revealed Resident #96 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. The MDS revealed the resident was not taking an anticoagulant medication at the time of admission. Resident #96's Order Recap [recapitulation] Report, reflecting orders for the timeframe from 07/05/2024 through 08/28/2024, contained an order, dated 08/08/2024, for Eliquis (an anticoagulant) 5 milligrams (mg) with instructions to administer two tablets twice a day. Per the report, this order was placed on hold on 08/22/2024 while the resident was hospitalized and discontinued on 08/25/2024. The Order Recap Report also contained an order, dated 08/25/2024, for Eliquis 5 mg with instructions to administer one tablet two times a day for blood clotting prevention. Resident #96's Medication Administration Record (MAR), for the timeframe from 08/01/2024 through 08/31/2024, revealed staff documented the resident began receiving Eliquis on 08/08/2024. The MAR revealed staff documented that the resident did not receive their Eliquis from 08/21/2024 at 9:00 PM through 08/25/2024 at 9:00 AM due to a hospitalization . Per the MAR, the resident began receiving their Eliquis again on 08/25/2024 at 9:00 PM. Resident #96's care plan did not include a focus area related to the use of an anticoagulant medication. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/29/2024 at 10:53 AM, Registered Nurse (RN) #7 stated the use of anticoagulant medications should be included on a resident's care plan. During an interview on 08/29/2024 at 11:26 AM, RN #2 stated if a resident was using an anticoagulant medication, then it should be included on the resident's care plan. She stated the nurse managers developed the care plans, but the nurses working the floor could update them. During an interview on 08/29/2024 at 12:32 PM, RN #8 stated she was the nurse manager for the floor where Resident #96 resided. She stated the use of an anticoagulant medication should be included on a resident's care plan. During an interview on 08/29/2024 at 2:04 PM, the Director of Nursing Services (DNS) stated residents on anticoagulants should be monitored for bleeding and bruising, and it should be addressed on their care plan.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 36105 Based on observation, interview, record review, and facility policy review, the facility failed to ensure urinary catheter care was completed in a sanitary manner to prevent possible infection for 1 (Resident #202) of 1 resident sampled for urinary catheter use. Findings included: A facility policy titled, Urinary Catheter Care, dated 03/2021, specified, The purpose of this procedure is to prevent catheter-associated urinary tract infections. The section of the policy titled, Steps in the Procedure included 7. Wash the resident's genitalia and perineum thoroughly with soap and water. Rinse the area well and towel dry, 16. For a male resident male [sic]: Use a washcloth with warm water and soap to cleanse around the meatus [the opening at the tip of the penis where urine exits the body] . Cleanse the glans using circular strokes from the meatus outward. Change the position of the washcloth with each cleansing stroke. With a clean washcloth, rinse with warm water using the above technique. Return foreskin to normal position. 17. Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward. An Admission Record revealed the facility admitted Resident #202 on 10/21/2021. According to the Admission Record, the resident had a medical history that included diagnoses of hydronephrosis (excess of fluid in a kidney due to a build-up of urine), tubulo-interstitial nephritis (swollen tubules in a kidney), benign prostatic hyperplasia (enlarged prostate), obstructive and reflux uropathy (obstructed urinary flow), and retention of urine. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/04/2024, revealed Resident #202 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident had an indwelling urinary catheter and was dependent on staff for toileting hygiene. Resident #202's care plan included a focus area, initiated on 05/09/2024, that indicated the resident was at risk for complications, including a urinary tract infection, due to use of an indwelling urinary catheter. An intervention initiated on 05/09/2024 directed staff to provide indwelling catheter care daily and as needed. Resident #202's Order Summary Report, for the timeframe from 01/01/2024 through 08/28/2024, contained a physician's order, dated 06/06/2024, for catheter care to be provided every shift. The order indicated to cleanse the site with soap and warm water, rinse, and pat dry. During an observation of catheter care for Resident #202 on 08/28/2024 beginning at 2:30 PM, Certified Nursing Assistant (CNA) #12 washed the creases (sides) of the resident's pubic area with a soapy washcloth and then squeezed the excess soapy water from the washcloth over the resident's entire pubic area. The CNA then used the same washcloth to clean the resident's penis by wiping from the base towards the meatus of the penis. CNA #12 did not use a clean soapy washcloth to cleanse the penis from the meatus to the base and did not rinse the area before she dried the area. CNA #12 also did not clean the resident's catheter tubing. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/28/2024 at 2:34 PM, CNA #12 stated the resident would be receiving catheter care on the next shift, and indicated the soap would be rinsed off at that time. CNA #12 proceeded to rinse and re-dry the area at that time, again wiping from the base of the penis towards the meatus. During an interview on 08/28/2024 at 2:58 PM, CNA #12 stated that per procedure, she should have pulled the catheter tubing out a couple of inches from the resident's penis to clean it, but the resident was too sensitive to do it. During an interview on 08/28/2024 at 2:52 PM, CNA #13 stated staff should rinse soap off a resident's skin because it could leave a film and compromise the integrity of the skin by drying out the skin. She stated she was trained on catheter care to always clean from the tip of the penis towards the base. She stated to clean from the base of the penis to the tip (meatus) might cause infection by bacteria entering the opening of the penis. CNA #13 stated she was trained to hold the catheter tubing in place and clean the tubing down several inches, especially if the resident wore a brief, because feces could get on the tubing and could cause a urinary tract infection. During an interview on 08/28/2024 at 3:02 PM, the Director of Staff Development (DSD) stated she was a licensed vocational nurse (LVN) who assisted the charge nurse on the floor Resident #202 resided. She stated for a male resident during catheter care, staff should clean the penis from the tip down toward the body. She stated that after that, staff should hold the catheter tubing in place and wipe down the tubing at least two inches from the penis. The DSD stated that cleaning a male from the base of the penis to the tip increased the potential risk of a urinary tract infection by bacteria entering the opening of the penis. During an interview on 08/28/2024 at 3:24 PM, the Infection Preventionist (IP) stated the CNA should have cleaned the male resident during perineal and catheter care by cleaning from the tip of the penis down toward the body. She stated the CNA should have then held the catheter tubing and cleaned down the tubing a few inches. She stated the way CNA #12 performed catheter care increased the chance of bacteria entering the opening of the penis and causing a urinary tract infection. She stated the washed areas of skin should always be rinsed, because if soap were left on the skin, it could dry out and irritate the skin, especially in the perineal area. During an interview on 08/29/2024 at 2:06 PM, the Director of Nursing Services (DNS) stated catheter care should be performed by cleaning from the meatus towards the base of the penis. She stated that infection was more likely when cleaning from the base of the penis to the tip of the penis. The DNS stated the soap left on the resident was considered dirty and should have been rinsed off. During an interview on 08/29/2024 at 2:44 PM, the Administrator stated he thought that during catheter care, the penis should be cleaned from the tip of the penis down toward the body. He stated staff should follow infection control procedures when providing catheter care. The Administrator stated he expected soap to be rinsed off the resident for their comfort.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 35314 Based on observation, interview, and facility document and policy review, the facility failed to ensure nurse staffing data was posted on a daily basis at the beginning of each shift, and failed to ensure the posting was in a prominent place readily accessible to residents. This deficiency had the potential to affect all residents residing in the facility. Findings included: A facility policy titled, Posting Direct Care Daily Staffing Numbers, revised in 07/2016, revealed, Our facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. The policy revealed, 1. Within two (2) hours of the beginning of each shift, the number of Licensed Nurses (RNs [registered nurses], LPNs [licensed practical nurses], and LVNs [licensed vocational nurses]) and the number of unlicensed nursing personnel (CNAs [certified nursing assistants]) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format. The facility's floor plan revealed residents' rooms were located on the second, third, fourth, and fifth floors; there were no resident rooms located on the first floor. An observation on 08/26/2024 at 12:42 PM revealed a California Department of Public Health (CDPH) Census and Direct Care Service Hours Per Patient Day (DHPPD) document, dated 08/22/2024, was posted in the first-floor lobby area. An observation on 08/27/2024 at 8:36 AM revealed the same CDPH Census and Direct Care Service Hours Per Patient Day (DHPPD) document, dated 08/22/2024, was posted in the first-floor lobby area. Observations on 08/27/2024 from 8:38 AM to 8:49 AM revealed no daily staffing data was posted on the second, third, fourth, or fifth floors. Observations on 08/28/2024 beginning at 10:30 AM revealed no daily staffing data was posted on the second, third, fourth, or fifth floors. During an interview on 08/28/2024 at 9:48 AM, the Staffing Coordinator revealed the CDPH staffing data form was posted in the lobby. She stated that the residents could not see the postings unless they went downstairs to the lobby. The Staffing Coordinator stated the daily staffing data should be posted daily, before each shift, but indicated she was on vacation from 08/23/2024 through 08/27/2024. The Staffing Coordinator confirmed that when she returned to work, she noticed the daily staffing data posting was dated 08/22/2024. She stated that, in her absence, the Director of Nursing Services (DNS) or a morning nurse manager was responsible for posting the daily staffing data in the lobby. During an interview on 08/28/2024 at 11:20 AM, RN #8 said she was the nurse manager for the morning shift on 08/26/2024. She stated she counted the nurses and aides on shift and reported the information to the DNS. Per RN #8, the DNS was responsible for posting the staffing data information when the Staffing Coordinator was not working. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 08/29/2024 at 9:14 AM, the DNS stated she or the nurse managers completed the staffing data postings when the Staffing Coordinator was not working and confirmed that she had not completed the staff postings. The DNS further stated the staffing data was posted in the lobby; the DNS stated this location was not accessible to the residents. During an interview on 08/29/2024 at 11:08 AM, the Administrator stated the daily staffing data was only posted in the lobby and should be posted by 9:00 AM each day.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 36105 Based on observation, interview, record review, and facility policy review, the facility failed to ensure medications were received from the pharmacy in a timely manner for 3 (Resident #38, #96, and Resident #308) of 11 sampled residents reviewed for pharmacy services. Findings included: A facility policy titled, Medication Ordering and Receiving from Pharmacy, effective 01/2022, specified, Medications and related products are received from the dispensing pharmacy on a timely basis. The facility maintains accurate records of medication order and receipt. 1. An Admission Record revealed the facility admitted Resident #38 on 07/18/2024. According to the Admission Record, the resident had a medical history that included diagnoses of hypertensive heart disease with heart failure and hyperlipidemia (elevated cholesterol level). An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/24/2024, revealed Resident #38 had a BIMS score of 15, which indicated the resident had intact cognition. Resident #38's care plan included a focus area, initiated on 07/21/2024, that indicated the resident was at risk for cardiac distress related to atrial fibrillation, congestive heart failure, hyperlipidemia, and hypertension (high blood pressure). An intervention initiated on 07/21/2024 directed staff to administer prescribed medication. Resident #38's Order Summary Report for the timeframe from 07/18/2024 through 08/28/2024 contained a physician's order, dated 07/18/2024, for losartan potassium tablet 100 milligrams (mg), one time per day for hypertension. The Order Summary Report also contained an order, dated 07/18/2024, for atorvastatin calcium tablet 20 mg, one tablet in the evening for hyperlipidemia. Resident #38's August 2024 Medication Administration Record (MAR) revealed losartan potassium was scheduled to be administered daily at 9:00 AM. The MAR revealed Licensed Vocational Nurse (LVN) #1 documented 9, which indicated Other/See Progress Notes, for the scheduled doses on 08/11/2024, 08/19/2024, 08/20/2024, 08/21/2024, 08/26/2024, and 08/27/2024. The MAR also revealed that Registered Nurse (RN) #2 documented 9 for losartan potassium on 08/23/2024 and 08/24/2024. Resident #38's Progress Notes, dated 08/11/2024 at 11:18 AM, 08/19/2024 at 10:36 AM, 08/20/2024 at 11:51 AM, 08/21/2024 at 10:31 AM, and 08/26/2028 at 10:53 AM, revealed LVN #1 documented the resident's losartan was pending. Progress Notes dated 08/23/2024 at 9:11 AM and 08/24/2024 at 8:56 AM revealed RN #2 documented that losartan was on order. The Progress Notes revealed no documented evidence Resident #38's physician was notified that the resident's medication was not available and was not administered to the resident. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #38's August 2024 MAR revealed atorvastatin was scheduled to administered daily at 5:00 PM. The MAR revealed RN #4 documented 9 for the scheduled doses on 08/19/2024, 08/20/2024, 08/26/2024, and 08/27/2024. The MAR also revealed RN #3 documented 9 on 08/21/2024, 08/22/2024, 08/23/2024, and 08/24/2024. Resident #38's Progress Notes dated 08/19/2024 at 5:49 PM, 08/20/2024 at 5:21 PM, 08/21/2024 at 9:51 PM, 08/22/2024 at 10:10 PM, 08/23/2024 at 8:27 PM, 08/24/2024 at 7:02 PM, and 08/26/2024 at 5:23 PM, revealed staff documented Resident #38's atorvastatin medication was on order, pending pharmacy delivery, or waiting for delivery. During an observation of medication administration on 08/27/2024 at 8:57 AM, LVN #1 stated Resident #38's losartan was not available in the medication cart. During an interview on 08/27/2024 at 9:17 AM, LVN #1 stated she knew the losartan refill had been requested from the pharmacy. During a follow-up interview on 08/28/2024 at 1:38 PM, LVN #1 stated the MAR entry, 9 Other/See Progress Notes, meant the medication had not been administered, and there was an associated progress note. LVN #1 stated pending in her progress notes meant they were waiting for a refill from the pharmacy. LVN #1 stated she should have called the pharmacy again. During an interview on 08/28/2024 at 1:48 PM, Unit Manager (UM) #6 stated if a resident's medications were not available, the nurses should notify the pharmacy. UM #6 stated it was particularly important for residents to receive their blood pressure medication. UM #6 stated the nurses should document the situation and any calls to the pharmacy in the progress notes. UM #6 stated she expected the nurses to report to her if there was a missing medication that was not delivered, and she, or the evening supervisor, would follow up with the pharmacy. During an interview on 08/29/2024 at 1:35 PM, RN #3 stated she was unsure how the system worked and whether she should reorder medication. During an interview on 08/29/2024 at 12:23 PM, RN #2 stated the process for missing medication was to call the physician, notify the unit manager, and call the pharmacy. During an interview on 08/29/2024 at 1:46 PM, Physician #5 stated he was not aware of any missing medications but expected the nurse to notify someone in their clinic group if any medication was missing and could not be given. Physician #5 stated he had never heard of this type of delay in medication delivery. During an interview on 08/29/2024 at 2:15 PM, the Director of Nursing Services (DNS) stated the nurses should have followed up with the pharmacy because they were waiting for the refill. The DON stated, if medication was not available in the facility to give, the nurses should always inform the pharmacy and the physician and document it. The DON stated, if a resident did not receive medication, they could have problems if their blood pressure was too high. The DON stated the pharmacy and the physician should have been notified, and it should have been documented. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/29/2024 at 2:39 PM, the Administrator stated his expectation was for the pharmacy to deliver the medications that were ordered. The Administrator stated the residents needed the medications, and that was why they were ordered. The Administrator stated he expected the nurses to notify the pharmacy, notify the physician, monitor the resident's blood pressure, and document for any missing medication. 45555 2. An Admission Record indicated the facility admitted Resident #308 on 08/02/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of type two diabetes mellitus with hyperglycemia (high blood sugar). An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/08/2024, revealed Resident #308 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Per the MDS, the resident had received six insulin injections during the seven days prior to the assessment. The MDS revealed the physician had not changed the resident's insulin orders in the previous seven days. Resident #308's care plan included a focus area, initiated on 08/02/2024, that indicated the resident was at risk for hypoglycemia (low blood sugar) and hyperglycemia. An intervention initiated on 08/02/2024 directed staff to administer prescribed insulin as ordered. Resident #308's Order Recap [recapitulation] Report for the timeframe from 08/02/2024 through 08/28/2024 revealed an order, started on 08/07/2024, for Ozempic (used to improve blood sugar levels) 2 milligrams (mg) per 3 milliliters (ml), with instructions to inject 0.25 mg subcutaneously, once every seven days for diabetes mellitus. Resident #308's August 2024 Medication Administration Record (MAR) revealed Registered Nurse (RN) #2 documented a code 9, indicating Other/See Progress Note, for the resident's Ozempic each week it was due to be administered, on 08/07/2024, 08/14/2024, and 08/21/2024. Resident #308's Progress Notes revealed Orders-Administration Notes, dated 08/07/2024, 08/14/2024, and 08/21/2024, that indicated the resident's Ozempic was on order. A Refills Orders Only form revealed Resident #308's Ozempic was ordered on 08/15/2024. There was a handwritten note on the side of the form to send the high-cost form, if needed. A Notice of Non-Covered/High-Cost Drug form revealed the authorization for the Ozempic was signed by the Director of Nursing Services (DNS) on 08/21/2024. A pharmacy delivery manifest indicated Resident #308's Ozempic was received by the facility on 08/22/2024 at 5:19 AM. During an interview on 08/28/2024 at 8:17 AM, Registered Nurse (RN) #8, the nurse manager for the 4th and 5th floors, stated Ozempic was a high-cost medication that had to have prior approval. RN #8 stated the pharmacy would usually let them know when they had a high-cost medication that needed authorization, but the facility did not receive the form, and the medication nurses did not know it was a high-cost medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/28/2024 at 3:35 PM, RN #8 stated they did not realize Resident #308's Ozempic was not in the facility until it was due to be administered on 08/07/2024. RN #8 stated the charge nurse called the pharmacy to find out where the medication was and reordered it. RN #8 stated, again, they did not realize that the medication was not in the facility until it was due to be given on 08/14/2024. RN #8 stated on 08/15/2024, the Ozempic was put on a refill order sheet that was sent to the pharmacy. RN #8 stated she followed up a few days later and found that the medication was not in the facility, so she resent the order sheet with a note that said to send the high-cost form, if it was needed. RN #8 stated the high-cost form was signed on 08/21/2024, and the medication was received at the facility on 08/22/2024. During an interview on 08/29/2024 at 10:29 AM, Case Manager (CM) #9 stated that when a resident was admitted to the facility all medications from their hospital discharge medication list were entered into the electronic charting system, and then the medication list was printed and faxed to the pharmacy with the resident's admission record, so that the pharmacy could deliver the medications. CM #9 stated the next morning, after a new admission, the nurse managers were supposed to review all the medications that were received and follow up on any that were not delivered. CM #9 stated she was not able to say why Resident #308's medications were not available. During an interview on 08/29/2024 at 10:53 AM, RN #7 stated every charge nurse was responsible for ensuring that all the medications were received from the pharmacy. RN #7 stated the nurse that was working the medication cart was the person responsible for following up if medications were not available. During an interview on 08/29/2024 at 11:26 AM, RN #2 stated that when Resident #308's Ozempic was not available the first week, she notified the manager, who called the pharmacy. RN #2 stated the next week, when the Ozempic was not available, she notified the manager and added the Ozempic to a pharmacy order form. RN #2 stated that when the Ozempic was not available again the next week, the manager wrote a note on the order form to send the high-cost form, and the facility received the Ozempic a few days later. RN #2 stated she should have reported the missing medication to the next shift to follow up on, and they should have done that every shift until the medication was received. During an interview on 08/29/2024 at 12:32 PM, RN #8 stated that if a medication was not available during medication pass, the nurse should call the pharmacy to expedite the delivery of the medication. RN #8 stated that if the medication was scheduled to be administered once a week, the nurse should follow up daily until the medication was received. During an interview on 08/29/2024 at 2:04 PM, the Director of Nursing Services (DNS) stated that when a medication was not available, the nurse should follow up with the pharmacy. The DNS stated the nurse should ask the pharmacy when they should expect the delivery of the medication. The DNS stated they should continue to follow up on obtaining the medication until it was received. The DNS stated Resident #308's Ozempic should have been followed up on. During an interview on 08/29/2024 at 2:49 PM, the Administrator stated if they ordered medications from the pharmacy, the medications should be available in a timely manner. The Administrator further stated that if a medication was not available, the facility should be notified of when the medication was going to arrive. (continued on next page)

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	056176	A. Building B. Wing	08/29/2024

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Pacific Heights Transitional Care Center	2707 Pine Street San Francisco, CA 94115

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. An Admission Record indicated the facility admitted Resident #96 on 07/05/2024. According to the Admission Record, the resident had a medical history that included diagnoses of acute on chronic diastolic congestive heart failure (CHF) and history of pulmonary embolism (blood clot in a lung). A 5-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/09/2024, revealed Resident #96 had a BIMS score of 00, which indicated the resident had severe cognitive impairment. The MDS indicated the resident had taken an anticoagulant medication in the seven days prior to the assessment. Resident #96's Order Recap [recapitulation] Report for the timeframe from 07/05/2024 through 08/28/2024, contained an order, dated 08/08/2024, for Eliquis (an anticoagulant) 5 milligrams (mg) with instructions to administer two tablets twice a day for blood clotting prevention until 08/14/2024. Resident #96's August 2024 Medication Administration Record (MAR) for Eliquis revealed Registered Nurse (RN) #7 documented a code 9, which indicated Other/See Progress Note, for the resident's medication administration on 08/11/2024 at 9:00 PM and on 08/12/2024 at 9:00 AM. Resident #96's Progress Notes revealed an Orders-Administration Note dated 08/11/2024 and 08/12/2024 that indicated the resident's Eliquis was pending delivery. During an interview on 08/29/2024 at 10:53 AM, RN #7 stated every charge nurse was responsible for ensuring that all the medications were received from the pharmacy. RN #7 stated the nurse that was working the medication cart was the person responsible for following up if medications were not available. During an interview on 08/29/2024 at 12:32 PM, RN #8 stated that if a medication was not available during medication pass, the nurse should call the pharmacy to expedite the delivery of the medication. During an interview on 08/29/2024 at 2:04 PM, the Director of Nursing Services (DNS) stated that when a medication was not available, the nurse should follow up with the pharmacy. The DNS stated the nurse should ask the pharmacy when they should expect the delivery of the medication. The DNS stated they should continue to follow up on obtaining the medication until it was received. During an interview on 08/29/2024 at 2:49 PM, the Administrator stated if they ordered medications from the pharmacy, the medications should be available in a timely manner. The Administrator further stated that if a medication was not available, the facility should be notified of when the medication was going to arrive.

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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. 45555 Based on interview and record review, the facility failed to monitor for potential side effects or adverse drug reactions related to the use of an anticoagulant (blood thinner) for 1 (Resident #96) of 5 residents reviewed for unnecessary medications. Findings included: An Admission Record indicated the facility admitted Resident #96 on 07/05/2024. According to the Admission Record, the resident had a medical history that included diagnoses of acute on chronic diastolic (congestive) heart failure (CHF) and personal history of pulmonary embolism (a blood clot in a lung). A 5-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/09/2024, revealed Resident #96 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was taking an anticoagulant medication. Resident #96's Order Recap [recapitulation] Report, reflecting orders for the timeframe from 07/05/2024 through 08/28/2024, contained an order, dated 08/08/2024, for Eliquis (an anticoagulant) 5 milligrams (mg) with instructions to administer two tablets twice a day. Per the report, this order was placed on hold on 08/22/2024 while the resident was hospitalized and discontinued on 08/25/2024. The Order Recap Report also contained an order, dated 08/25/2024, for Eliquis 5 mg with instructions to administer one tablet two times a day for blood clotting prevention. The Order Recap Report contained no orders to monitor for side effects or adverse drug reactions related to the resident's use of Eliquis. Resident #96's August 2024 Medication Administration Record (MAR) and August 2024 Treatment Administration Record (TAR) revealed documentation that indicated the resident's Eliquis was administered, but there was no documentation of monitoring for side effects or adverse drug reactions related to the resident's use of Eliquis. Resident #96's Progress Notes for the timeframe from 08/08/2024 through 08/28/2024 revealed no documentation of monitoring for side effects or adverse drug reactions related to the resident's use of Eliquis. During an interview on 08/29/2024 at 10:53 AM, Registered Nurse (RN) #7 stated residents on anticoagulants should be monitored for bleeding and bruising. She stated residents receiving an anticoagulant should have an order for monitoring entered into their electronic record and indicated the monitoring should be documented on the MAR. She confirmed that Resident #96 did not have an order to monitor for side effects related to the use of the Eliquis. During an interview on 08/29/2024 at 11:26 AM, RN #2 stated a residents on anticoagulant medications should be monitored for bleeding and bruising, and the monitoring should be documented on the MAR every shift. RN #2 confirmed monitoring for bleeding and bruising was not included on Resident #96's MAR but stated it should have been. (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 08/29/2024 at 12:32 PM, RN #8 stated she was the Nurse Manager responsible for the 4th and 5th floors. She stated residents receiving an anticoagulant should have an order for monitoring and indicated the monitoring should be documented on the MAR. RN #8 stated the admitting nurse was responsible for ensuring the order to monitor was put in place. During an interview on 08/29/2024 at 2:04 PM, the Director of Nursing Services (DNS) stated the nurses should be monitoring residents on anticoagulants for bleeding and bruising and documenting their findings on the MAR.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 45555 Based on interview, record review, and facility policy review, facility failed to obtain laboratory testing as ordered by the physician for 1 (Resident #308) of 5 residents reviewed for unnecessary medications. Findings included: A facility policy titled, Request for Diagnostic Services, revised in 04/2007, indicated, 3. Orders for diagnostic services will be promptly carried out as instructed by the physician's order. An Admission Record indicated the facility admitted Resident #308 on 08/02/2024. According to the Admission Record, the resident had a medical history that included diagnoses of malignant neoplasm (cancer) of the anal canal, secondary malignant neoplasm of the bladder, type two diabetes mellitus with hyperglycemia, essential hypertension, iron deficiency anemia, and hyperlipidemia. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/08/2024, revealed Resident #308 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #308's care plan included a focus area, initiated on 08/02/2024, that indicated the resident had a potential for complications such as infections and physical decline. An intervention initiated on 08/02/2024 directed staff to follow up on laboratory testing as ordered and report abnormal findings to the physician. Resident #308's Order Recap [recapitulation] Report, for the timeframe from 08/02/2024 through 08/28/2024, contained an order, dated 08/15/2024, to obtain a complete blood count (CBC) and basic metabolic panel (BMP) weekly. The order included a note for the night nurse to print a requisition form. Resident #308's August 2024 Medication Administration Record (MAR) revealed Registered Nurse (RN) #7 signed the MAR indicating the CBC and BMP were completed on 08/23/2024. Resident #308's electronic health record and paper record revealed no documented evidence the facility completed a CBC and BMP for Resident #308 on 08/23/2024. During an interview on 08/29/2024 at 10:53 AM, RN #7 stated that when a resident had an order for routine laboratory testing, staff entered the order into the laboratory's online platform, printed off a laboratory requisition form, and placed the requisition form into a laboratory binder. She stated the nighttime nurse filled out the requisition form, and the floor nurse was responsible for ensuring the laboratory specimen was obtained and signed off on the MAR when it was obtained. RN #7 stated she was responsible on 08/23/2024 for ensuring Resident #308's laboratory testing was done. She stated she saw the laboratory staff in the facility and assumed they completed Resident #308's laboratory tests, but she did not verify that a laboratory requisition was completed or that a blood specimen was collected for testing. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/29/2024 at 11:26 AM, RN #2 stated if a routine laboratory test was due for collection, it showed up on the resident's MAR for the night shift to print the laboratory requisition from. She stated that when she came to work in the morning, she checked the laboratory binder and printed off laboratory requisitions, if needed. RN #2 stated the nurse was responsible for ensuring the laboratory specimens were collected and for following up on laboratory results. During an interview on 08/29/2024 at 2:04 PM, the Director of Nursing Services (DNS) stated that in the past, if a routine laboratory test was due, the lab would automatically complete the testing; however, currently, the facility had to print a requisition form and place it in the laboratory binder. The DON stated the laboratory staff only completed laboratory testing for the requisitions in the binder. She stated the nurse manager for the unit should ensure that a requisition was in place and was also responsible for ensuring laboratory testing was obtained and that staff followed up with the provider. She stated she was not sure why Resident #308's laboratory testing was missed. During an interview on 08/29/2024 at 2:49 PM, the Administrator stated staff should be following physician's orders and scheduled laboratory tests should be obtained.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 36105 Based on observation, interview, and facility policy review, the facility failed to follow procedures to prevent potential infections and cross-contamination during medication administration for 2 (Resident #305 and Resident #56) of 7 residents observed during medication administration. Findings included: A facility policy titled, Medication Administration (General), dated 08/18/2022, specified, 25. Staff shall follow established facility infection control procedures (e.g. [exempli gratia, for example], handwashing, antiseptic technique, gloves, isolation precautions, etc. [et cetera]) for the administration of medications, as applicable. During an observation of medication administration on 08/28/2024 at 8:36 AM, Registered Nurse (RN) #2 placed Resident #305's medications in a medication cup. RN #2's placed her bare hand around the lip-surface of a cup of water provided to the resident to use while taking their medications. At 8:40 AM, Resident #305 took their medications and drank from the cup of water. During an observation of medication administration on 08/28/2024 at 8:44 AM, RN #2 sanitized her hands and prepared Resident #56's medications. RN #2 placed her bare hand around the lip-surface of a cup of water provided to the resident to use while taking their medications. During an interview on 08/28/2024 at 8:47 AM, RN #2 stated she should not have touched the lip-surface of the water cups while passing medications, because it could result in possible cross-contamination and risk of infection. During an interview on 08/28/2024 at 3:34 PM, RN #8 stated she was a nurse manager. RN #8 stated nurses should not touch the lip-surface of water cups with bare hands because touching the cups contaminated them. During an interview on 08/28/2024 at 3:19 PM, the Infection Preventionist (IP) stated RN #2 should not have touched the lip-surface of the water cups. She stated that although RN #2 sanitized her hands, their hands would not be considered clean. The IP stated she expected nurses to use a tray to deliver medications and not place their hands on the lip-surface of cups, where a resident would place their mouth, because it could cause a risk of infection. During an interview on 08/29/2024 at 2:03 PM, the Director of Nursing Services (DNS) stated the nurse should not have touched the lip-surface of the water cups. During an interview on 08/29/2024 at 2:37 PM, the Administrator stated he expected nurses to hold water cups lower on the cup, below the lip-surface, because of infection control concerns.