STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056188	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Long Beach Care Center, Inc	2615 Grand Avenue Long Beach, CA 90815

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45028 Based on observation, interview, and record review the facility failed to ensure three out of 16 sampled residents (Resident 10, Resident 33, and Resident 61) were treated with dignity and respect by failing to: 1.Acknowledge the call lights for Resident 10 and Resident 33 when they needed assistance. This deficient practice had the potential to cause a safety risk of residents getting out of bed and falling due to their call lights not being answered and had a potential of not meeting the needs of Resident 10 and Resident 33 resulting in feelings of not being important and low self-esteem. 2. Ensure Certified Nurse Assistant (CNA) 3 fed Resident 61 lunch while sitting at eye level. This deficient practice had the potential for Resident 61 to feel as though they were not treated with dignity and respect. Findings: During a review of Resident 10's Admission Record, the Admission Record indicated Resident 10 was admitted to the facility on [DATE] with diagnoses of major depressive disorder (a mental health condition that causes a persistently low mood and a loss of interest in activities that once brought joy), anxiety disorder (persistent and excessive worry that interferes with daily activities), and suicidal ideations (thoughts of killing oneself). During a review of Resident 10's Minimum Data Set ([MDS] a standardized assessment and screening tool) dated 5/10/2024, the MDS indicated Resident 10 was cognitively (relating to, being, or involving conscious intellectual activity (such as thinking, reasoning, or remembering) intact. The MDS indicated Resident 10 was substantial/ maximum assist (the staff does more than half of the effort) for toileting, showers, and personal hygiene. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 33's Admission Record, the Admission Record indicated Resident 33 was admitted to the facility on [DATE] with diagnoses of major depressive disorder and schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). The MDS indicated Resident 33 needed set up or clean-up assistance (resident completes activity, staff just helps) with all activities of daily living (ADLs, are those skills required to manage one's basic physical needs, including personal hygiene or grooming, dressing, toileting, transferring or ambulating, and eating). During a review of Resident 33's MDS dated [DATE], the MDS indicated Resident 33 was cognitively intact. During an observation and concurrent interview on 7/16/2024 at 9:40 a.m., Resident 10's call light was on above her room and a beeping sound could be heard in the hallway, Resident 10 stated she pressed her call light because she wanted the remote control for her bed. Resident 10 stated she had been screaming like a mad woman because no one had come to answer her call light. Resident 10 stated it was a common occurrence that staff would not answer her call light in a timely manner. During an observation on 7/16/2024 at 9:42 a.m., licensed vocational nurse (LVN1) was observed standing in the doorway next to Resident 10's room while the call light was on and beeping. LVN1 continued standing by her medication cart and did not respond to the call light for Resident 10. During an observation on 7/16/2024 at 9:48 a.m., certified nursing assistant (CNA1) answered the call light for Resident 10. During an interview on 7/16/2024 at 9:54 a.m., CNA 1 stated it was the obligation of all staff in the facility to respond to call lights if they were activated by a resident. CNA 1 stated facility staff should not be waiting for CNAs to answer the call lights. CNA 1 stated that anyone could have answered the call light for Resident 10 because she only wanted her bed remote control. CNA 1 stated she felt bad that Resident 10's call light was not answered right away. During an observation on 7/16/2024 at 9:59 a.m., Resident 33's call light turned on and could be heard beeping in the hallway. LVN 1 walked past the room with the call light beeping and walked back to her medication cart down the hall without responding to the call light. During an observation on 7/16/2024 at 10:03 a.m., LVN1 sat down at the nurse's station directly in front of Resident 33's room with the call light still lit and an audible beeping could be heard. During an observation on 7/16/2024 at 10:08 a.m., CNA 1 responded to the call light for Resident 33 while LVN 1 was still sitting at the nurse's station directly across from Resident 33's room. During an interview on 7/16/2024 at 10:12 a.m., LVN1 stated she had just finished her morning medication administration and was finishing her documentation. LVN 1 stated it was all staff's responsibility to answer call lights including LVN's. LVN 1 stated staff know a call light was activated by the beeping sound and at the light that goes on above the door and on the call light panel directly across the nurse's station. LVN 1 stated she did not realize Resident 10 and Resident 33 had been calling for help. LVN 1 confirmed the call light system was working. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/19/2024 at 12:49 p.m., the Director of Staff Development (DSD) stated anyone who has a badge who works here can answer the call lights and it was not only the responsibility of the CNAs to answer call lights. The DSD stated, there was a possibility to delay the needs of the residents if call lights were not answered in a timely manner. During an interview on 7/19/2024 at 4:35 p.m., Registered nurse (RN 1) stated the potential outcome of not answering the call lights right away was residents' safety may be affected and the residents' needs may not be met in a timely manner. RN1 stated the call lights needed to be answered right away and by any employee that saw the call light turned on. During a review of the facility's policy and procedure (P/P) titled Call lights: Accessibility and Timely Response dated 11/2017, the P/P indicated all staff members who see or hear an activated call light were responsible for responding. The P/P indicated staff was to listen to the resident's request and respond accordingly and staff was to inform the resident if they were unable to meet the need and assure him/her that the staff would notify the appropriate personnel. b. During a review of Resident 61's Admission Record, the Admission Record indicated Resident 61 was admitted to the facility on [DATE] with diagnoses including gastro-esophageal reflux disease ([GERD] stomach acid repeatedly flows back up into the tube connecting the mouth and stomach), hypertension (high blood pressure), and bipolar disorder (a serious mental illness which causes unusual shifts in mood, ranging from extreme highs to lows). During a review of Resident 61's History and Physical (H&P) dated 11/4/2023, the H&P indicated Resident 61 had fluctuating capacity to understand and make medical decisions. During a review of Resident 61's MDS dated [DATE], the MDS indicated Resident 61's cognition was moderately impaired and had the ability to understand and be understood by others. The MDS indicated Resident 61 had functional impairment on one upper extremity and required setup or clean-up assistance from staff for eating. During an observation on 7/16/2024 at 12:31 p.m., in Resident 61's room, CNA 3 was observed feeding Resident 61 lunch. CNA 3 was observed standing to the right of Resident 61 while he was seated in his wheelchair. CNA 3 was not feeding Resident 61 at eye level. During a concurrent observation and interview on 7/16/2024 at 12:34 p.m. with CNA 4 in Resident 61's doorway, CNA 3 was observed standing over Resident 61 and feeding him lunch. CNA 4 stated CNA 3 should be at eye level while feeding a resident their meal. CNA 4 stated it is important for staff to feed a resident at eye level because we are supposed to treat every resident with respect and dignity. During an interview on 7/16/2024 at 1:18 p.m., with CNA 3, CNA 3 stated that she was not at eye level with Resident 61 when she was feeding him lunch. CNA 3 stated she should have been sitting at eye level with Resident 61. During an interview on 7/19/2024 at 12:49 p.m., the DSD, when staff are feeding a resident, they must be at eye level to promote dignity, show respect to the resident, and so eye contact can be made without excessive twisting or turning from the resident which can make the resident uncomfortable. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's undated policy and procedure P/P titled, Promoting/Maintaining Resident Dignity, the P/P indicated it is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. During a review of the facility's undated P/P titled, Resident Rights, the P/P indicated the facility will inform the resident both orally and in writing, in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. During a review of the facility's P/P titled Call lights: Accessibility and Timely Response dated 11/2017, the P/P indicated all staff members who see or hear an activated call light were responsible for responding. The P/P indicated staff was to listen to the resident's request and respond accordingly and staff was to inform the resident if they were unable to meet the need and assure him/her that the staff would notify the appropriate personnel. 45891

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45028 Based on interview and record review, the facility failed to ensure an investigation was conducted following a resident-to-resident altercation between Residents 18 and 61. This deficient practice resulted in the facility not identifying other potential residents who may have had resident-to-resident altercations not being identified and had a potential for further resident-to-resident altercations to occur between Resident 18 and 61. Findings: a. During a review of Resident 18's Admission Record, the Admission Record indicated Resident 18 was admitted to the facility on [DATE]with diagnoses including osteoarthritis (when the cartilage that cushions the ends of bones in the joints gradually deteriorates), acute kidney failure (the rapid loss of the kidney's ability to remove waste and help balance fluids in the body), and gastro-esophageal reflux disease ([GERD] stomach acid repeatedly flows back up into the tube connecting the mouth and stomach). During a review of Resident 18's History and Physical (H&P) dated 2/10/2024, the H&P indicated Resident 18 can make needs known but cannot make medical decisions. During a review of Resident 18's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 7/15/2024, the MDS indicated Resident 18 had severe cognitive (ability to make decisions of daily living) impairment and was sometimes understood and was able to sometimes understand others. The MDS indicated Resident 18 had no functional limitations in movement. b. During a review of Resident 61's Admission Record, the Admission Record indicated Resident 61 was admitted to the facility on [DATE] with diagnoses including gastro-esophageal reflux disease, hypertension (high blood pressure), and bipolar disorder (a serious mental illness which causes unusual shifts in mood, ranging from extreme highs to lows). During a review of Resident 61's History and Physical (H&P) dated 11/4/2023, the H&P indicated Resident 61 had fluctuating capacity to understand and make medical decisions. During a review of Resident 61's MDS dated [DATE], the MDS indicated Resident 61's cognition was moderately impaired and had the ability to understand and be understood by others. The MDS indicated Resident 61 had functional impairment on one upper extremity and required setup or clean-up assistance from staff for eating. During an observation on 7/16/2024 at 10:18 a.m., in Resident 18 and 61's room, Resident 61 was observed crawling on the floor towards Resident 18's bed. Resident 18 was observed sitting on his bed with his back towards Resident 61. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 7/16/2024 at 10:22 a.m., in Resident 18 and 61's room, Resident 61 was observed grabbing the footrests of a wheelchair that was to the left of Resident 18's bed. Resident 18 was observed getting out of bed, walking over to Resident 61, grabbing the handles of the wheelchair, then shaking the wheelchair and yelling at Resident 61 stating Get out of here, get your hands off the wheelchair, what are you doing! Resident 18 was observed attempting to hit Resident 61 with the wheelchair. During a continued observation on 7/16/2024 at 10:23 a.m., in Resident 18 and 61's room, Certified Nurse Assistant (CNA) 3 was observed walking into Resident 18 and 61's room and stopping the altercation between Resident 18 and 61. During an interview on 7/16/2024 at 1:18 p.m., with CNA 3, CNA 3 stated she notified Licensed Vocational Nurse (LVN) 3 of the resident-to-resident altercation between Resident 18 and 61. During an interview on 7/17/2024 at 9:47 a.m., with the Administrator (ADM), the ADM stated he was not notified of the resident-to-resident altercation between Resident 18 and 61 that occurred on 7/16/2024. During a follow-up interview on 7/19/2024 at 5:04 p.m., with the ADM, the ADM stated the Licensed Vocational Nurse (LVN) 1 stated she didn't consider what occurred between Resident 18 and 61 on 7/16/2024 as an altercation because Resident 18's method of communication is yelling. The ADM stated LVN 1 should have immediately reported what occurred between Resident 18 and Resident 61 to him so he could have started an immediate investigation. During a review of the facility's undated policy and procedure (P&P) titled, Abuse, Neglect and Exploitation, the P&P indicated when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur, an investigation is immediately warranted. Once the resident is cared for and initial reporting has occurred, an investigation should be conducted.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958 Based on interview and record review, the facility failed to appropriately assess one of one sampled resident (Resident 152) who was visually impaired. This deficient practice resulted to inaccurate assessment of Resident 152's vision leading to a potential delay in care and needed vision services. Findings: During a review of Resident 152's Admission Record (Face Sheet) the Face Sheet indicated Resident 152 was admitted to the facility on [DATE] with diagnoses including vision loss, schizoaffective disorder (condition where person will experience delusions and hallucinations), and muscle weakness. During a review of Resident 152's Resident admission assessment document, dated 7/1/2024, the assessment indicated Resident 152 is legally blind. During a review of Resident 152's care plan, dated 7/3/2024, the care plan indicated the following concerns Resident 152 is at risk for injury related to unspecified vision loss. The care plan indicated the following goals, resident is at risk for injury related to unspecified vision loss will be minimized daily for three month, by October 2024. During a review of Resident 152's MDS, dated [DATE], the MDS indicated Resident 152 had the ability to think, learn, remember, use judgement, and make decisions and could understand and be understood by others. The MDs indicated Resident 152 had adequate (sees fine detail, such as regular print in newspapers and books) ability to see in adequate light. During a concurrent interview and record review on 7/19/2024, at 5 p.m., with Minimum Data Set Nurse (MDSN) 2, Resident 152's MDS assessment dated [DATE] was reviewed. The MDS assessment indicated Resident 152 had adequate ability to see in adequate light. MDSN 2 stated when I asked Resident 152 if she could see, Resident 152 stated she could see me. MDSN 2 stated Resident 152 appeared to make eye contact but I did not assess properly or ask Resident 152 if she had any difficulty reading books or paperwork or seeing objects. MDSN 2 stated she should have reviewed Resident 152 's Resident Admission assessment dated [DATE] and care plan dated 7/3/2024. MDSN 2 stated failure to conduct an appropriate assessment resulted in the inaccurate determination of resident's vision and could result in a delay of care and services. During an interview on 7/19/2024, at 5:30 p.m., the Director of Nursing (DON) stated it was important for the MDSN 2 to complete a proper assessment in order to ensure Resident 152 received the proper care and services needed to address her visual impairment. The DON stated MDSN 2 should have thoroughly assessed Resident 152's ability to see, reviewed Resident 152's documents and interviewed staff caring for Resident 152 to verify any visual limitations. The DON stated the inaccurate MDS assessment resulted in an inaccurate visual assessment which could lead to ineffective care planning and delay in care and services for Resident 152. During a record review of the Resident Assessment Instrument (RAI) require that (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(1) the assessment accurately reflects the resident's status.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45028 Based on interview and record review, the facility failed to follow through with the Preadmission Screening and Resident Review ([PASRR] a tool to ensure possible individuals with mental illnesses or intellectual disabilities are appropriately placed in nursing homes for long term care) recommendation to obtain a PASRR Level II (helps determine placement and specialized services) evaluation for three of three sampled residents (Resident 4, 60 and 61). This failure had the potential to result in inappropriate placement and unidentified specialized services for Resident 4, 60 and 61. Findings: a. During a review of Resident 4's Face Sheet, the Face Sheet indicated Resident 4 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including basal cell carcinoma (cancer- body's cells grow uncontrollably and spread to other parts of the body) of the skin of the nose, malignant neoplasm (abnormal growth of tissue or cells) of right lacrimal (tear duct) gland and major depressive episode (condition causes severe sadness interfering with daily life). During a review of Resident 4's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 6/24/2024, the MDS indicated Resident 4 had severe cognitive impairment affecting Resident 4's the ability to think, learn, remember, use judgement, and make decisions. The MDS indicated Resident 4 could usually understand and be understood by others. The MDS indicated Resident 4 was dependent (helper does all the effort) or required substantial/maximal assistance (helper does more than half the effort) with eating, oral hygiene, toileting hygiene, showering, dressing, and bathing. During a review of Resident 4's PASARR Level I completed on 2/21/2024, the PASARR Level I indicated the need for a PASAAR Level II evaluation. During a review of Resident 4's medical records, the medical records indicated there was no PASARR Level II completed. b. During a review of Resident 60's Face Sheet, the Face Sheet indicated Resident 60 was admitted to the facility on [DATE] with diagnosis including chronic kidney (one of a pair of organs in the abdomen which remove waste and extra water from the blood) disease (when the kidneys can't filter blood the way they should), hypertensive heart disease (heart problems which occur because of high blood pressure which is present over a long time) and depression (a constant feeling of sadness and loss of interest, which stops a person from doing their normal activities). During a review of Resident 60's History and Physical (H&P) dated 12/7/2023, the H&P indicated Resident 60 had fluctuating capacity to understand and make decisions. During a review of Resident 60's MDS dated [DATE], the MDS indicated Resident 60's cognition was moderately impaired and had the ability to understand and be understood by others. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 60's PASARR Level I completed on 4/12/2024, the PASARR Level I indicated the need for a PASARR Level II evaluation. During a review of Resident 60's medical records, the medical records indicated there was no PASARR Level II completed. c. During a review of Resident 61's Face Sheet, the Face Sheet indicated Resident 61 was admitted to the facility on [DATE] with diagnosis including gastro-esophageal reflux disease, hypertension (high blood pressure), and bipolar disorder (a serious mental illness which causes unusual shifts in mood, ranging from extreme highs to lows). During a review of Resident 61's History and Physical (H&P) dated 11/4/2023, the H&P indicated Resident 61 had fluctuating capacity to understand and make medical decisions. During a review of Resident 61's MDS dated [DATE], the MDS indicated Resident 61's cognition was moderately impaired and had the ability to understand and be understood by others. During a review of Resident 61's PASARR Level I completed on 3/28/2024, the PASARR Level I indicated the need for a PASARR Level II evaluation. During a review of Resident 61's medical records, the medical records indicated there was no PASARR Level II completed. During a concurrent interview and record review on 7/18/2024 at 4:18 p.m., with Minimum Data Set Nurses (MDSN) 1 and 2, Resident 4's, 60's and 61's PASARR Level I's were reviewed. Resident 4, 60 and Resident 61's PASARR Level I's indicated PASARR Level II evaluation was required. The MDSN 1 and 2 confirmed that there was no documented evidence indicating PASARR Level II was completed for Resident 4, 60 and Resident 61. The MDSN 1 and 2 stated a PASARR Level II is important because it provides the special recommendations, and it lets the facility know if the resident requires specialized services. The MDSN 1 and 2 stated if the PASARR Level II is not completed, and the resident requires specialized services, there is a potential for a delay in specialized services for the resident. During a review of the facility's undated policy and procedure (P/P) titled, Resident Assessment - Coordination with PASARR Program, the P/P indicated all individuals with a mental disorder or intellectual disability who apply for admission to this facility will be screened in accordance with the State's Medicaid rules for screening. Recommendations, such as any specialized services, from a PASARR level II determination and/or PASARR evaluation report will be incorporated into the resident's assessment, care planning, and transitions of care. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958 Based on observation, interview, and record review, the facility failed to develop and implement an individualized person-centered plan of care with interventions to meet the residents' needs for one of two sampled residents (Resident 152). The facility failed to: Ensure Resident 152's, care plan interventions to include call light within reach and implemented by CNA 5 prior to leaving the residents' room. CNA 5 was not aware Resident 159 was visually impaired. This deficient practice had the potential to put Resident 152 at risk for injury, delays the provision of care and is a violation of residents' rights. Findings: During a review of Resident 152's Admission Record (Face Sheet) the Face Sheet indicated Resident 152 was admitted to the facility on [DATE] with diagnoses including vision loss, schizoaffective disorder (condition where person will experience delusions and hallucinations), and muscle weakness. During a review of Resident 152's MDS, dated [DATE], the MDS indicated Resident 152 had the ability to think, learn, remember, use judgement, and make decisions and could understand and be understood by others. During a review of Resident 152's care plan, dated 7/3/2024, the care plan indicated Resident 152 at risk for injury related to unspecified vision loss. The care plan indicated a goal to minimized risk for injury, related to unspecified vision loss. The care plan interventions indicated the following maintain hazard and safe environment, announce self when getting near the resident, explain procedures and talk to resident while giving care, assess for eye pain/problem and report to medical doctor, provide adequate light for activities of daily living. During a concurrent observation and interview on 7/17/2024 at 8:16 a.m., with Resident 152 in Resident 152's room, Resident 152 was observed sitting in a wheelchair at the foot of the bed. Resident 152's call light observed to be on bed out of reach for resident. Resident 152 stated she likes to have the call light on the handrail of her wheelchair where she can reach it. Resident 152 stated she does not know where her call light and will yell to call for assistance. Resident 152 was observed to yell for the nurse. During an observation on 7/17/2024 at 8:18 a.m., in Resident 152's room, CNA 6 was observed to enter Resident 152's room. CNA 6 provided Resident 152 with assistance and left the room, Resident 152's call light was observed laying on the bed not within reach. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/17/2024 at 8:20 a.m., with CNA 6, CNA 6 stated she was Resident 152's assigned CNA for the day shift (7am- 330pm). CNA 6 stated she was aware Resident 152's call light was on the bed while Resident 152 was sitting in the wheelchair at the foot of the bed. CNA 6 stated she did not notify Resident 152 the location of the call light before leaving the room because she thought Resident 152 could see the call light on the bed. CNA 6 stated she did not know Resident 152 could not see the call light. CNA 6 stated failure to ensure Resident 152 could see the call light put Resident 152 at risk for injury and delay in receiving needed assistance. During an interview on 7/19/2024, at 5:25 p.m., the Director of Nursing (DON) stated it was important for the nursing staff to implement resident's care plans to ensure residents received timely and appropriate care. The DON stated the nursing staff must ensure residents with visual impairments have their call lights in reach prior to leaving the residents' room. The DON stated failure to ensure a visually impaired resident has their call light in reach puts the resident at risk for injury, delays the provision of care and is a violation of residents' rights. The DON stated interventions to ensure resident's call light is in reach should be included in a resident's care plan. During a review of the facility's policy and procedure, (P/P) titled, Comprehensive Person-Centered undated, the P/P indicated it is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with residents' rights, that includes measurable objectives and times frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958 Based on observation, interview and record review, the facility failed to revise the comprehensive resident centered care plan for one of three sampled residents (Resident 88). The facility failed to ensure Resident 88's care plan interventions were specific to include the need for direct line of sight (unobstructive view) monitoring for Resident 88. This deficient practice placed Resident 88 at high risk for harm due to falls or accidents. Findings: During a review of Resident 88's Admission Record, the Admission Record indicated Resident 88 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including schizophrenia (mental disorder affecting the ability to think, reason, make decisions), muscle weakness and polyarthritis (pain and swelling in joints). During a review of Resident 88's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 4/9/2024, the MDS indicated Resident 88 had severe cognitive impairment (ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 88 used a wheelchair and was dependent (helper does all the effort, resident does none of the effort) on staff for transferring from bed to chair, moving from sitting to lying down and for all Activities of Daily living (ADLs-grooming, bathing, toileting, eating, dressing). During a review of Resident 88's Fall Risk Assessment, an assessment to predict resident's risk of falls, dated 7/9/2024, the assessment indicated Resident 88 was always disoriented, chair bound, had poor vision and unable to stand. The assessment indicated Resident 88 scored 13. The assessment indicated a total score of 10 or more represents high risk for falls. During an observation on 7/18/2024, at 8:30 a.m., Resident 88 was observed to be sitting in a wheelchair unsupervised in her room. Resident 88 was observed to be moving her legs up and down while sitting in the wheelchair. Resident 88 was unable to answer questions. During an interview on 7/18/2024, at 8:40 a.m., Registered Nurse (RN) 1 stated, Resident 88 was in a wheelchair in her room unattended. RN 1 stated Resident 88 needs to be supervised by staff and cannot be left alone in her room when in a wheelchair. RN 1 stated Resident 88 has poor safety awareness (unable make safe decisions to prevent one from falling or being injured) and was at high risk for falling out of her chair. Resident 88 requires line of sight supervision from staff and must be placed at the nursing station or in the dining room when she was sitting in a wheelchair. During an interview on 7/18/2024, at 11:20 a.m., Certified Nurse Assistant (CNA) 7 stated she left Resident 88 in the room unattended in a wheelchair because she needed to assist another resident. CNA 7 stated all residents in the facility were fall risk but Resident 88 does not listen to instructions and constantly moves her legs in the wheelchair. CNA 7 stated she should have asked another staff member to move Resident 88 next to the nurses' station into the dining room where other staff can see her. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 7/18/2024 at 4:30 p.m., with the RN 1, Resident 88's care plan, initiated 6/17/2024 was reviewed. The care plan indicated Resident 88 was at risk for falls/ injuries related to Alzheimer's disease (disorder that destroys memory and thinking skills) and osteoarthritis (swelling and pain in joints), resident has a fall risk assessment score of 13. The care plan goal indicated the following: minimize the risk for falls and decrease significant injury as a result from fall. The care plan indicated the following interventions update fall assessment, assess resident for propensity for falls, evaluate current fall prevention interventions, assess/anticipate/ intervene for factors causing prior falls, encourage resident to attend and participate in activities, provide resident with a safe and clutter free environment, assist resident with transfers with 2+ staff and mechanical lift as needed .RN 1 stated the care plan does not include specific interventions addressing the need for Resident 88 line of sight supervision. RN 1 stated failure to revise the care plan to include the specific intervention placed Resident 88 at risk for further falls. During an interview on 7/19/2024, at 5:30 p.m., the Director of Nursing (DON) stated the nursing staff must use residents' care plans to guide their care every shift. The DON stated, nursing staff must use review and revise resident care plans to reflect their resident specific needs. The DON stated failing to revise Resident 88's care plans to reflect the specific needs of the Residents 88 can lead to a delay in needed care and services and the risk for falls. The DON stated the Interdisciplinary team ([IDT] team of healthcare working together from different specialties) should have revised Resident 88's care plan to include the intervention direct line of sight ensuring Resident 88 is never left attended in her room while in a wheelchair and instead should be placed near the nurses' station or in the dining room. During a review of the facility's policy and procedure, (P/P) titled, Comprehensive Resident Centered Plan of Care revised November 2018, the P/P indicated it was the policy of the facility to provide person-centered, comprehensive, and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain maintain the highest physical, mental, and psychosocial well-being. The P/P indicate qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the intervention, initially and when changes are made.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958 Based on observation, interview and record review, the facility failed to ensure one of three sample residents (Resident 129) who was receiving enteral (nutrition delivering into the body with the aid of a feeding tube) feedings received appropriate care and services to prevent complications of enteral feedings. The facility failed to ensure the licensed nursing staff appropriately assessed Resident 129 to be positioned with the head of bed (HOB- head of resident's bed elevated) at 35-45 degrees. This deficient practice resulted in potential harm resulting from aspiration (when fluid accidentally enters windpipe into the lungs) for Resident 129. Findings: During a review of Resident 129's Admission Record (Face Sheet) the Face Sheet indicated Resident 129 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (loss of the ability to think, remember and reason), dysphagia (difficulty swallowing) and encephalopathy (damage or disease affecting brain). During a review of Resident 129's Minimum Data Set ([MDS]) a standardized assessment and care-screening tool, dated 7/11/2024, the MDS indicated Resident 129 had severe cognitive impairment affecting his ability to think, learn, remember, use judgement, and make decisions. The MDS indicated Resident 129 was dependent on staff for hygiene, toileting, showering/bathing, dressing, and turning and repositing. The MDS indicated Resident 129 had a feeding tube. During a review of Resident 129's physician's orders, dated 6/6/2024, the physician orders indicated elevate Resident 129's HOB between 35-45 degrees during feeding times. During a review of Resident 129's care plan, dated 6/10/2024, the care plan indicated the following concerns Resident 129 has potential for alteration in comfort related to Gastroesophageal reflux disease (GERD-condition in which the stomach contents move into esophagus [food pipe]) without esophagitis (inflammation of esophagus). The care plan indicated the following goal, resident's potential for alteration in comfort related to GERD will minimize daily for three HOB between 35-45 degrees during feeding time. During a concurrent observation and interview on 7/18/2024 at 1:07 p.m., with Certified Nurse Assistant (CNA) 5 in Resident 129's room, Resident 129 was observed lying in bed with his head tilted and angled downward toward the left side of the bed. Resident 129's head of bed was lower 35 degrees. Resident 129's feeding pump was observed to be infusing enteral feedings. CNA 5 stated Resident 129 was not positioned safely in bed and needed to be repositioned in order to elevate the HOB. LVN 4 was observed to enter Resident 129's room and leave without speaking to CNA 5 or assisting Resident 129. CNA 5 stated she required the assistance of an LVN to turn off Resident 129's enteral feeding pump. CNA 5 stated she was not sure why LVN 4 left the room without turning off Resident 129's due to his unsafe position. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 7/18/2024 at 1:10 p.m., with CNA 5 in Resident 129's room, CNA 5 was observed to use the call light to ask for assistance. LVN 4 was observed to walk into Resident 129's bedside and ask CNA 5 if she needed anything. CNA 5 asked LVN 4 to turn off Resident 129's enteral feeding pump in order to reposition Resident 129. LVN 4 was observed to turn off the enteral feeding pump and leave the bedside and Resident 129's room. LVN 4 did not assess nor provide assistance to Resident 129. During an interview on 7/18/2024, at 1:12 p.m., LVN 4 stated she walked into Resident 129's room twice while CNA 5 was in the room but did not assess or pay attention to Resident 129's HOB position. LVN 4 stated, I saw CNA 5 in the room and I didn't stay because CNA 5 looked like she was ready to assist Resident 129. LVN 4 stated Resident 129 had a gastrostomy (surgically placed tube inserted into the stomach to deliver nutrition and medication) tube and was receiving enteral feedings. LVN 4 stated she should have assessed Resident 129 to ensure he was positioned properly when she walked into the room. LVN 4 stated a resident with a Gtube must be reassessed frequently at least every two hours or less while enteral feeds are infusing to ensure the resident is tolerating the feedings and properly positioned with the HOB at 35- 45 degrees. LVN 4 stated she last checked Resident 129's position earlier in the morning. LVN 4 stated failing to reassess Resident 129 regularly while enteral feedings are infusing places Resident 129 at risk for aspiration. During an interview on 7/19/2024, at 5:25 p.m., the Director of Nursing (DON) stated the nursing staff must assess residents receiving enteral feedings frequently, at least every two hours to ensure the resident is tolerating the enteral feedings and positioned properly. The DON stated failure to ensure proper positioning places a resident receiving enteral feedings at risk for aspiration. During a review of the facility's policy and procedure, (P/P) titled, Enteral Nutrition revised 2023, the P/P indicated adequate nutritional support through enteral feedings will be provided to the resident as ordered. The P/P indicated the risk of aspiration will be assessed by the nurse and physician and addressed in the individual care plan, risk of aspiration may be affected by diminished level of consciousness, moderate to severe swallowing difficulties, improper positioning for the resident during feedings, and failure to confirm placement of the feeding tube prior to initiating the feeding.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 45028 Based on observation, interview, and record review, the facility failed to ensure staffing information was posted and readily available to residents and visitors. This deficient practice resulted in residents and visitors not being able to access accurate daily numbers of clinical staff taking care of residents. Findings: During an observation on 7/16/2024 at 10:57 a.m., at the facility entrance, there was no daily staffing information posted. During a concurrent observation and interview on 7/16/2024 at 11:02 a.m., with Registered Nurse (RNS) 1, at the nurse's station and front entry doors, there was no daily staffing information posted. RNS 1 stated there was no daily staffing information posted at the nurse's station nor the front entry. RNS 1 stated the daily staffing information should be posted at the front entry way double doors. During a concurrent observation and interview on 7/16/2024 at 11:13 a.m., with the Director of Staff Development (DSD), the DSD stated she is responsible for posting the daily staffing information at the facility's entryway but did not post the daily staffing information for the day. The DSD stated the daily staffing information should be posted at the beginning of the shift to let visitors and residents know the staffing information for the day. During a review of the facility's Policy and Procedure (P/P) titled, Nurse Staffing Posting Information, revised 11/2017, the P/P indicated the facility will post the Daily Staffing Sheet at the beginning of each shift.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45891 Based on observation, interview, and record review the facility failed to track and record the administration of controlled substances (a medication/ drug or other substance that is tightly controlled by the government because it may be abused or cause addiction) in real time for four out of 54 (Resident 34, Resident 82, Resident 115, and Resident 149) sampled Residents. This deficient practice had the potential to cause medication errors (any preventable event that may cause or lead to inappropriate medication use or patient harm) and the potential for drug diversion (illegal distribution or abuse of prescription drugs or their use for purposes not intended by the prescriber). Findings: During a review of Resident 34's Admission Record, the Admission Record indicated Resident 34 was admitted to the facility on [DATE] with diagnoses of anxiety disorder (persistent and excessive worry that interferes with daily activities) and schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). During a review of Resident 34's MDS dated [DATE], the MDS indicated Resident 34 was severely cognitively impaired. The MDS indicated Resident 34 was receiving medication for anxiety. During a review of Resident 115's Admission Record, the Admission Record indicated Resident 115 was admitted to the facility on [DATE] with diagnoses of anxiety disorder, schizophrenia, and major depressive disorder (a mental health condition that causes a persistently low mood and a loss of interest in activities that once brought joy). During a review of Resident 115's Minimum Data Set (MDS, a standardized assessment and screening tool) dated 4/22/2024, the MDS indicated Resident 115's cognition (the mental process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired. The MDS indicated Resident 115 was receiving medication for anxiety. During a review of Resident 149's Admission Record, the Admission Record indicated Resident 149 was admitted to the facility on [DATE] with diagnoses of schizophrenia and major depressive disorder. During a review of Resident 149's MDS dated [DATE], the MDS indicated Resident 149 was cognitively intact. During a review of Resident 82's Admission Record, the Admission Record indicated Resident 82 was admitted to the facility on [DATE] with a diagnosis of suicidal ideations (thoughts of killing oneself). During a review of Resident 82's MDS dated [DATE], the MDS indicated Resident 82 was cognitively intact. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 115's physician orders for the month of 7/2024, an order was placed on 7/8/2024 for Lorazepam (Ativan, an anxiety medication) 1 milligram (mg, a unit of measurement of weight) tablet every 6 hours as needed (PRN) for anxiety manifested by (m/b) irritability. During a review of Resident 34's physician's orders for the month of 7/2024, an order was placed on 7/9/2024 for Lorazepam 1 mg tablet every 6 hours PRN for anxiety m/b inability to relax. During a review of Resident 149's physician orders for the month of 7/2024, an order was placed on 7/12/2024 for Alprazolam (Xanax, an anxiety medication) 1 mg tablet twice daily (every 12 hours) for anxiety m/b verbalization of feeling anxious. During a review of Resident 82's physician orders for the month of 7/2024, an order was placed on 7/16/2024 for Lorazepam 1mg tablet every 6 hours PRN for anxiety m/b pacing in hallways. During an observation, record review, and concurrent interview on 7/18/2024 at 8:53 a.m., with licensed vocational nurse (LVN 2) a medication storage check was done on Station B medication cart number 3. A narcotic count was performed, and these were the findings: a. For Resident 34, the bubble pack (a form of tamper-evident packaging) for Lorazepam 1 mg tablets contained 15 tablets. The Controlled Drug Record log for Resident 34's Lorazepam 1 mg tablet indicated the bubble pack should have contained 16 tablets, LVN 2 stated he had given Resident 34 her Lorazepam 1 mg tablet that morning because she was feeling anxious, but he had not yet documented the medication administration on the Controlled Drug Record log. b. For Resident 82, the bubble pack for Lorazepam 1 mg tablets contained four tablets. The Controlled Drug Record log for Resident 82's Lorazepam 1 mg tablet indicated the bubble pack should have contained five tablets, LVN 2 stated he had given Resident 82 his Lorazepam 1 mg tablet that morning because he was feeling anxious, but he had not yet documented the medication administration on the Controlled Drug Record log or the medication administration record (MAR). c. For Resident 115, the bubble pack for Lorazepam 1 mg tablet contained 17 tablets. The Controlled Drug Record log for Resident 115's Lorazepam 1 mg tablets indicated the bubble pack should have contained 18 tablets, LVN 2 stated he gave Resident 115 his Lorazepam that morning because he was yelling and pacing in the hallway, but he had not yet documented the administration in the Controlled Drug Record log. d. for Resident 149, the bubble pack for Alprazolam 1 mg tablet contained 24 tablets. The Controlled Drug Record log for Resident 149's Alprazolam 1 mg tablets indicated the bubble pack should have contained 25 tablets, LVN 2 stated he gave Resident 149 her Alprazolam that morning because she was feeling anxious, but he had not yet documented the administration on the Controlled Drug Record log. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN 2 stated it was the facility's policy to document the administration of controlled substances right away (as soon as was popped out of the bubble pack and given,) in the MAR as well as the Controlled Drug Record. LVN 2 stated the Controlled Drug Record was important to account for the correct number of controlled substances on hand at any given time. LVN2 stated he was writing the times the controlled substances were given on his vital signs sheet (a piece of paper with handwritten vital signs for each of his residents) and was going to go back later and record the medication administration in the residents' records. LVN2 stated he should not have been charting that way and the medication administration should have been done in real time and not back dated (timed in the past). LVN2 stated he could have misplaced the vitals sign sheet and would not have been able to remember the times the medications were given. During an interview on 7/18/2024 at 10:16 a.m., registered nurse (RN 1) stated all controlled substances needed to be reconciled (system of recordkeeping that ensures an accurate inventory of medications by accounting for controlled substances that have been received, dispensed, AND administered) and documented as given in the MAR and Controlled Drug Record log as soon as the medication was administered. RN 1 stated it was important to document the medication administration right away because there was a potential that the licensed nurse would not go back and complete the administration documentation causing misinformation and the medication could be given by the next nurse too early, causing a medication reaction or possible overdose (excessive or dangerous dose of a drug). RN 1 stated it was important to have an accurate count of all controlled substances to ensure they are being given appropriately. During a review of the facility's policy and procedure (P/P) titled Medication Administration and dated 11/2017, the P/P indicated the nurse was to sign the MAR after administered and if the medication was a controlled substance, the nurse was to sign the narcotic book. During a review of the facility's P/P titled Charting and Documentation, undated, the P/P indicated all medications administered must be timely documented in the resident's chart.

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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** 45028 Based on interview and record review, the facility failed to ensure: a. physician gave informed consent (the process in which a health care provider educated a patient about the risks, benefits, and alternatives of a given procedure or intervention) before the administration of any psychotropic (capable of affecting the mind, emotions, and behavior) medication for one of eight sampled residents (Resident 14). b. Resident 4's Responsible Party (RP)and the Licensed Nurse who received the medication order and verified that medical doctor obtained informed consent (decision made freely by the resident or RP, after he/she had knowledge and understanding of the risks and benefits, available options about the various treatment alternatives) for the administration of Lorazepam (psychotherapeutic drug). c. informed consent was signed and dated for Resident 152 's administration of Invega Sustenna (psychotherapeutic drug) and Ativan (psychotherapeutic drug). These failures resulted in violation of resident's rights and had the potential for inappropriate use of psychotropic medications or unnecessary medications. Findings: During a review of Resident 14's Admission Record , the Admission Record indicated Resident 14 was admitted to the facility on [DATE] with diagnosis including major depressive disorder (a mood disorder which causes a persistent feeling of sadness and loss of interest), schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions) and suicidal ideations (thoughts of killing oneself). During a review of Resident 14's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 5/16/2024, the MDS indicated Resident 14 had severe cognitive impairment and sometimes had the ability to understand and be understood by others. The MDS indicated Resident 14 received antipsychotic (medication used to treat hallucinations [sights, sounds, smells, tastes, or touches which a person believes to be real but are not], delusions [false beliefs] and dementia) and antidepressant (medication used to treat depression) medications during the assessment period. During a review of Resident 14's Physician's Orders, dated 7/9/2024, indicated Resident 14 was prescribed the following medications: 1. Ativan (used to treat anxiety) 1 milligram ([mg] unit of measurement) every six hours for 14 days as needed for anxiety as manifested by irritability (a quick excitability to annoyance, impatience, or anger). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Lexapro (used to treat certain mental/mood disorders) 20 mg daily for depression (constant feeling of sadness and loss of interest, which stops a person from doing their normal activities) and withdrawal. 3. Risperdal (used to treat schizophrenia) 1 mg twice a day as manifested by paranoia (a mental disorder in which a person has an extreme fear and distrust of others). 4. Valproic Acid (use to treat epileptic seizures (a sudden alteration of behavior due to a temporary change in the electrical functioning of the brain), bipolar disorder (a serious mental illness which causes unusual shifts in mood ranging from extreme highs to lows), and to prevent migraine headaches (a headache which can cause severe throbbing pain or a pulsing sensations, usually on one side of the head) 100 mg every night and 750 mg daily in the morning as manifested by labile mood (emotional instability characterized by rapid and dramatic mood swings). During a review of Resident 14's Facility Verification of Resident Informed Consent for Psychotherapeutic Drugs for Ativan, Lexapro, Risperdal and Valproic Acid dated 7/9/2024, indicated the informed consent was obtained on 7/9/2024 at 2 p.m., however there was no signature from Resident 14's physician nor Resident 14's Conservator (a court-appointed person who is responsible for managing the financial and personal affairs of a person who is incapacitated [one's physical or mental inability to manage one's own affairs]) indicating informed consent was obtained by the physician. During an interview on 7/18/2024 at 4:10 p.m. with Registered Nurse Supervisor (RNS) 1, RNS 1 stated after reviewing Resident 14's informed consents for Ativan, Lexapro, Risperdal, and Valproic Acid, the consents were not signed and dated by the physician nor the Conservator. RNS 1 stated the physician must obtain informed consent and sign that the consent was obtained for all residents who are prescribed psychoactive medications prior to the medications being administered to the residents. RNS 1 stated if proper informed consent is not obtained, then the psychoactive medication should not be administered to the resident. b. During a review of Resident 4's Admission Record the Admission record indicated Resident 4 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including basal cell carcinoma (cancer- body's cells grow uncontrollably and spread to other parts of the body) of the skin of the nose, malignant neoplasm (abnormal growth of tissue or cells) of right lacrimal (tear duct) gland and major depressive episode (condition causes severe sadness interfering with daily life). During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 had severe cognitive impairment affecting Resident 4's the ability to think, learn, remember, use judgement, and make decisions. The MDS indicated Resident 4 could usually understand and be understood by others. The MDS indicated Resident 4 was dependent (helper does all of the effort) or required substantial/maximal assistance (helper does more than half the effort) with eating, oral hygiene, toileting hygiene, showering, dressing and bathing. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 7/19/2024, at 6 p.m., with Director of Nursing (DON), Resident 4's form titled Facility Verification of Resident informed Consent for Psychotherapeutic Drugs or Prolonged Use of a Device (consent form) for the psychotherapeutic medication Lorazepam 2milligrams (mg-unit of measurement)/ milliliter (ml-unit of measurement) undated was reviewed. The DON stated the purpose of the form is to ensure the resident or RP were informed of the reason for the medication/treatment, the risks and benefits of the treatment, the duration of the treatment and the resident's rights while receiving the treatment. The DON stated the medical doctor provides the information and obtains informed consent after which the licensed nurse verifies the informed consent was obtained by the physician by speaking with the resident or RP. The consent form indicated the following, the signature line and date for Resident 4's RP was blank, the area indicating the nurse verifying the medical doctor obtained from Resident 4's RP was blank. The DON stated Resident 4's consent form was not completed accurately. The DON stated the consent form should have included Resident 4's RP signature, date and the nurse verifying Resident 4's RP provided their informed consent. c. During a review of Resident 152's Admission Record (Face Sheet) the Face Sheet indicated Resident 152 was admitted to the facility on [DATE] with diagnoses including vision loss, schizoaffective disorder (condition where person will experience delusions and hallucinations), and muscle weakness. During a review of Resident 152's MDS, dated [DATE], the MDS indicated Resident 152 had the ability to think, learn, remember, use judgement, and make decisions and could understand and be understood by others. During a concurrent interview and record review on 7/19/2024, at 6 p.m., with Director of Nursing (DON), Resident 152's forms titled Facility Verification of Resident informed Consent for Psychotherapeutic Drugs or Prolonged Use of a Device (consent form) for the psychotherapeutic medication Ativan 0.5 mg and Invega Sustenna undated was reviewed. The consent form where the signature line and date for Resident 152 was blank. The DON stated signature indicates Resident 152 had given her consent to receive the medication. The DON stated failure to complete the consent form was a violation of resident rights. During a review of the facility's policy and procedure, (P/P) titled, Consent-informed undated, the P/P indicated the nurse will witness the informed consent (decision made freely by the resident or RP, after he/she had knowledge and understanding of the risks and benefits, available options about the various treatment alternatives) has been obtained by the physician from the resident or legal guardian for treatments, procedures and psychotropics with significant risk. The P/P indicated nurses are responsible for confirming documentation of informed consent on the medical record, the physician/RP signs and dates prior to treatment/procedure being performed, the completed consent form is placed in the resident's medical record. During a review if the facility's undated policy and procedure (P/P) titled, Use of Psychotropic Medications, the P/P indicated residents and/or representatives shall be educated on the risks and benefits of psychotropic drug use, as well as alternative treatments/non-pharmacological interventions. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's undated P/P titled, Consent-Informed, the P/P indicated informed consent is a decision made freely by the patient/resident or a legally authorized representative after he/she has full knowledge and understanding of the risks, benefits, and available options about the various treatment alternatives. The practice guidelines include: the physician signs and dates prior to treatment/procedure being performed and the patient/resident or legal guardian signs and dates prior to the treatment/procedure being performed.

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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. 45425 Based on observation, interview and record review, the facility failed to ensure the dietary staff (Cook 1 and [NAME] 2) were competent in safe and effective food preparation. This deficient practice resulted in [NAME] 1 and 2 not having the knowledge and competency to prepare a fortified meal (add vitamins and minerals that are not naturally present in food). Findings During an observation on 7/17/2024 at 11:39 a.m. with [NAME] 2 during tray line (meal preparation when trays are moved along an assembly line), [NAME] 2 was observed adding extra tomato sauce for a fortified meal. During an interview on 7/17/2024 at 11:40 a.m. and a subsequent interview at 3:24 p.m. with [NAME] 2, [NAME] 2 stated when a meal needs to be fortified, extra sauce or gravy was added. [NAME] 2 stated the purpose of fortified meal was to make the food easier to swallow for the residents. During an interview on 7/17/2024 at 11:42 a.m. with [NAME] 1, [NAME] 1 stated when a meal needs to be fortified, she would sprinkle cheese on top of it. During a review of a sign posted in the kitchen titled Fortified Diet, the sign indicated for lunch margarine 1 ounce or gravy 1 ounce should be added to the meal. During an interview on 7/19/2024 at 3:18 p.m. and a subsequent interview at 3:44 p.m. with the Dietary Regional Manager (RDM), the RDM stated the purpose of a fortified meal was to help the resident gain weight or maintain their weight. The RDM stated there was no record of [NAME] 1 and [NAME] 2 receiving education regarding how to prepare a fortified meal. During a review of the facility's job description titled Cook, undated, the job description indicated one of the job functions of the [NAME] is to ensure foods are in the proper form to meet the individualized needs of the residents. The job description indicated the [NAME] should maintain knowledge of current nutritional practice regarding therapeutic diets.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 45425 Based on observation, interview and record review, the facility failed to: 1.Label and date food stored and thawing in the refrigerator and freezer according to facility policy. This deficient practice placed the facility residents at risk for foodborne illness. 2.Ensure the chemical in the dishwasher used for sanitizing, was at the proper level of 50 ppm (parts per million). When the kitchen staff tested the sanitizer in the dishwasher, the test strip indicated the chemical level was 0 ppm. This deficient practice of insufficient chemical sanitizer in the dishwasher had the potential to lead to use of contaminated dishes and utensils for 140 of 142 residents in the facility residents and can cause foodborne illness -an infection or irritation of the gastrointestinal (GI) tract caused by food or beverages that contain harmful bacteria, parasites, viruses, or chemicals). Findings 1. During an observation on [DATE] at 8:56 a.m. the following was observed: In Freezer #3, three oven roasted turkey breast were not labeled with date received and expiration date. In Freezer #2, two bags of broccoli and one box of cookie dough were not labeled with date received and expiration date. In Refrigerator #1, ham, roasted slice bacon, and chicken thawing were missing date of when placed in refrigerator. In Refrigerator #5, five blue bowls were missing date and label of contents, a brown paper bag was missing date and label of contents, and a coffee creamer bottle missing date opened and expiration date. In Freezer #6, 4 boxes (containing 48 cups per box) of ice cream were missing date received and expiration date. During an interview on [DATE] at 8:56 a.m., with Dietary Aide (DA1), the DA 1 stated items should be labeled with date received and date when the food expires. DA 1 stated the purpose of labeling the food items is to ensure the food is thrown out when the food is expired. DA 1 stated if there is no date on the food items, there would be no way to know when to throw it out and it could lead to food poisoning and illness. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 8:58 a.m., with the Cook, the [NAME] stated food placed in the refrigerator for thawing should have been labeled with the date of when it was placed in refrigerator. The [NAME] stated if there is no date placed on the food items, it can lead to residents getting sick from potentially spoiled food. During an interview on [DATE] at 9:00 a.m., with Dietary Aide (DA 2), DA 2 stated items should be labeled with the date when it was placed in the freezer and when the item expires. 2. During an observation on [DATE] at 9:24 a.m., of DA 3 testing the chlorine levels of the dishwasher machine, the test strip did not change color to indicate chlorine levels in the sanitizing solution, the strip remained white indicating there was none. During an interview on [DATE] at 9:30 a.m., with DA 4 and DA 3, DA 4 stated the test strip should change colors when exposed to the fluid in the dishwasher indicating there was no chlorine in the sanitizing fluid. DA 4 stated the purpose of the dishwasher chemicals was to kill the germs on the dishes. During an interview on [DATE] at 3:29 p.m. with the Regional Dietary Manager (RDM), the RDM stated items placed in the refrigerators and freezers should be labeled with the date received to keep track of expiration dates. The RDM stated the facility does not want to feed the residents with food that was expired because it could negatively affect their health of the vulnerable residents. The RDM stated the chemicals in the dishwasher should be at certain level to sanitize the dishes and protect the resident from contaminated dishware and to serve food in a sanitary manner. During a review of the facility's policy titled Food storage: Cold Foods dated ,d+[DATE], the policy indicated all food will be labeled and dated. During a review of the facility's policy titled Warewashing dated ,d+[DATE], the policy indicated all dishware, serviceware, and utensils will be cleaned and sanitized after each use.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425 Based on interview and record review, the facility failed to implement the antibiotic stewardship program policy for one of one sampled resident (Resident 129) when an antibiotic (a substance used to kill bacteria and to treat infections) did not meet McGreer Criteria (criteria used to determine appropriate use of antibiotics). This deficient practice had the potential to increase antibiotic resistance and the resident to be provided antibiotics without justification. Findings: During a review of Resident 129's Admission Record, the Admission Record indicated Resident 129 was initially admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses including urinary tract infection (bacterial infection of the bladder). During a review of Resident 27's Minimum Data Set (MDS), standardized resident assessment and care screening tool dated 10/1/2023 indicated Resident 129's cognition (the ability to think and make decisions) was severely impaired. Resident 129 was not oriented to date or time and was unable recall recent events. During a review of Resident 129's physician order dated 6/6/2024, the physician order indicated Bactrim (Sulfamethoxazole and trimethoprim), DS (double strength) 500-160 milligram (mg) tab BID (twice a day) until 6/12/24 for UTI ([urinary tract infection], an infection in any part of the urinary system). During a review of Resident 129's Nursing Home Antimicrobial Stewardship Guide- Antibiotic Use Tracking Sheet dated June 2024, under the column indicating whether McGeer criteria were met, the tracking sheet indicated NOT MET. During an interview and concurrent record review of on 7/19/2024 at 1:13 p.m. with the Infection Prevention Nurse (IP), the IP stated Resident 129 was a readmission to the facility, and had antibiotics ordered, but did not meet McGeer criteria. The IP stated some residents come from the hospital with antibiotics, but the hospitals do not provide the criteria. The IP stated the physician was not called when Resident 129's antibiotic did not meet Mcgeer criteria for use. During an interview on 7/19/2024 at 5:25 p.m. with the Director of Nursing (DON), the DON stated the purpose of the antibiotic stewardship program was to ensure antibiotics were used appropriately by ensuring the antibiotics meet criteria. The DON stated the IP was responsible for following up when an antibiotic does not meet criteria. During a review of the facility's policy titled Antibiotic Stewardship Program (undated), the policy indicated, The McGeer criteria are used to determine whether or not to teat an infection with antibiotics, and Antibiotic orders obtained upon admission, whether new admission or readmission, to the facility shall be reviewed for appropriateness. The policy indicated the Infection Preventionist coordinates all antibiotic stewardship activities.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 45425 Based on observation and interview, the facility failed to keep Refrigerator #1 in working condition when Refrigerator #1 was observed to have a pool of water sitting at the bottom of the refrigerator. This deficient practice had the potential to result in rapid growth of bacteria that can cause foodborne illness (food poisoning). Findings During an observation on 7/16/2024 at 8:58 a.m. of Refrigerator #1, it was observed that ham, chicken, and bacon were being defrosted. Observed a standing water at the bottom under the container of defrosting chicken. During an interview on 7/16/2024 at 8:58 a.m. with [NAME] 1, [NAME] 1 stated water will drip from the top of the refrigerator and collect at the bottom of the refrigerator. [NAME] 1 stated that it has been going on for the last two weeks. [NAME] 1 stated that maintenance was notified and checked Refrigerator #1. [NAME] 1 stated it was not normal for the refrigerator to operate in that way and it could grow germs or bacteria. During an interview on 7/17/2024 at 3:29 p.m. with the Regional Dietary Manager (RDM), the RDM stated she sent a weekly report to the Administrator (ADM), who would follow up with maintenance regarding Refrigerator #1. The RDM stated Refrigerator #1 was not in ideal working condition because the water could contaminate the food stored in the refrigerator. During a review of a weekly report from the RDM dated 7/11/2024, the report indicated the refrigerator by the condiment station (Refrigerator #1) had a significant amount of water condensation (water which collects as droplets on a cold surface). During an interview on 7/17/2024 at 4:01 p.m. with the ADM, the ADM stated that he received a weekly report from the kitchen staff and was responsible for any items that need follow up. The ADM stated the weekly report was sent out on 7/11/2024 and he believes the maintenance department assessed Refrigerator #1 on 7/17/2024 and if needed would have a technician come to make any repairs. During an interview on 7/17/2024 at 4:45 p.m. with the Maintenance Supervisor (MS), the MS stated he was notified regarding Refrigerator #1 on either 7/11/2024 or 7/12/2024. The MS stated on 7/11/2024, he assessed Refrigerator #1 and cleaned the coils at the top of the refrigerator and the bottom of the refrigerator was dry. The MS stated the technician was supposed to come on 7/12/2024 but unable and would be at the facility on 7/18/2024.