STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056212	A. Building B. Wing	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Redwoods Post-Acute	1267 Meridian Avenue San Jose, CA 95125

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38087 Based on interview and record review, the facility failed to ensure an advance directive (AD, a written instruction, such as a living will or durable power of attorney for health care for when the individual becomes incapacitated) or Physician Orders for Life-Sustaining Treatment (POLST, document that specifies the medical treatments the resident wants to receive during serious illness) was completed for 3 of 31 sampled residents (Residents 29, 31, and 32). These failures could lead to the delivery of unnecessary or inappropriate medical services, which are against the residents' goals and wishes. Findings: Review of Resident 29's clinical record indicated he was initially admitted to the facility on [DATE]. Review of Resident 29's POLST form, dated 8/20/24, indicated the AD section of the POLST form was blank. The POLST form did not indicate if there was an advance directive in placed or it was not available. Further review of Resident 29's POLST form indicated the section titled Artificially Administered Nutrition was blank. The POLST form did not indicate Resident 29's choices regarding feeding tubes and artificial nutrition. Review of Resident 31's clinical record indicated she was initially admitted to the facility on [DATE]. Review of Resident 31's POLST form, dated 11/28/23, indicated the AD section of the POLST form was blank. The POLST form did not indicate if there was an advance directive in placed or it was not available. Review of Resident 32's clinical record indicated she was initially admitted to the facility on [DATE]. Review of Resident 32's POLST form, dated 8/7/24, indicated the AD section of the POLST form was blank. The POLST form did not indicate if there was an advance directive in placed or it was not available. During an interview and concurrent record review with the director of nursing (DON) on 1/17/25 at 12:01 p.m. , the DON reviewed the POLST forms for Residents 29, 31, and 32. She stated the admission nurse reviews the POLST form with the resident or their responsible party (RP) and discusses their wishes regarding medical treatment. The DON confirmed The POLST forms for Residents 29, 31, and 32 were incomplete. The DON stated all sections of the POLST forms should be completed and signed by the physician and the resident or their RP. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled Advance Directives, revised 9/2022, indicated the advanced directives would be honored in accordance with state and facility policy. Upon admission, the resident would be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44185 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive, resident-centered care plan for one out of eleven sampled residents, (Resident 301), when Resident 301's refusals to participate in the activities that were being offered was not care planned. This failure had the potential to result in the resident not receiving the intervention and monitoring necessary to maintain his highest level of well-being. Findings: During a concurrent observation and interview of Resident 301 on 1/14/25 at 9:30 a.m., Resident 301 was laying in his bed, alert, calm and verbally responsive. He was refusing to participate in activities. During another concurrent observation and interview of Resident 301 on 1/15/25 at 8:50 a.m., Resident 301 was in his bed and appeared calm and comfortable. He was still refusing to participate in activities. Review of Resident 301's admission record (document that contains information about a resident's admission to a healthcare facility) indicated, Resident 301 was readmitted to the facility on [DATE] with diagnoses including unspecified parkinsonism (group of neurodegenerative conditions that manifest with motor symptoms, including rigidity, tremors and bradykinesia), unspecified schizoaffective disorder (mental health condition that includes symptoms of both schizophrenia and mood disorders) and generalized muscle weakness (decreased strength in the muscles). Review of Resident 301's order listing report (list of orders for a resident, including the details of each order) indicated, Resident 301 may participate in activity program if not in conflict with treatment plan, revised on 12/27/24. During an interview with the activity assistant I (AA I) on 1/17/25 at 9:35 a.m., AA I verified that the resident refused to participate in activities and there was no care plan about his refusal to participate in activities and this behavior was not monitored and followed up. During a concurrent record review of Resident 301's care plans and interview with the assistant director of nursing A (ADON A) on 1/17/25 at 12:31 p.m., ADON A verified that there was no care plan of Resident 301's refusal to participate in activities and this behavior of refusing to participate in activities should have been care planned, monitored and followed up. During an interview with the director of nursing (DON) on 1/17/25 at 12:55 p.m., DON verified that Resident 301's refusal to participate in activities should have been care planned, monitored and followed up. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, revised March 2022, indicated, 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 comprehensive, person-centered care plan . reflects currently recognized standards of practice for problem areas and conditions . Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44185 Based on observation, interview and record review, the facility failed to provide care in accordance with professional standards of practice for two of thirty-one sampled residents, (Residents 8 and 400), when: 1. for Resident 8, there was no care plan, monitoring and follow-up of her hand contractures, and 2. for Resident 400, the staff took the blood pressure (BP, the force of blood pushing against the walls of the arteries) on the same arm where the resident has the AV fistula (arteriovenous fistula, connection that's made between an artery and a vein for dialysis access.) These failures had the potential for the residents, not to attain or maintain their highest practicable physical, mental, psychosocial well-being, and potential to cause injury. Findings: During a concurrent observation and interview of Resident 8 on 1/14/25 at 8:45 a.m., Resident 8 was laying in her bed, alert, calm, comfortable and verbally responsive. Resident 8's hands were contracted and she verbalized that she's not getting therapy of her contracted hands anymore which could be very helpful. Review of Resident 8's admission record (document that contains information about a resident's admission to a healthcare facility) indicated, Resident 8 was admitted to the facility on [DATE] with diagnoses including hemiplegia (complete paralysis on one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebral infarction (type of stroke that occurs when the brain tissue dies due to lack of blood flow) affecting right dominant side, type 2 diabetes mellitus (chronic condition characterized by high levels of sugar in the blood) with diabetic chronic kidney disease (condition that occurs when diabetes damages the kidneys over time) and generalized muscle weakness (decreased strength in the muscles). Review of Resident 8's clinical records indicated that the hand contractures of Resident 8 were not care planned, monitored and followed up. During another concurrent observation and interview of Resident 8 with assistant director of nursing A (ADON A) on 1/16/25 at 3:35 p.m., Resident 8 was laying in her bed, calm and comfortable. Resident 8 stated that therapy and follow-up of her hand contractures will be good for her. During an interview with ADON A on 1/16/25 at 3:48 p.m., ADON A verified the hand contractures of Resident 8 and stated that they should have been care planned, monitored and followed up to prevent deterioration of the hand contractures. During an interview with the director of nursing (DON) on 1/17/25 at 12:50 p.m., DON acknowledged that the hand contractures of Resident 8 should have been care planned, monitored and followed-up to avoid the hand contractures, from getting worse. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedure titled, Activities of Daily Living (ADLs), revised March 2018, indicated, Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs) . Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice. The resident's response to interventions will be monitored, evaluated and revised as appropriate . 50855 2.During a review of Resident 400's clinical record indicated, Resident 400 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (a condition in which the kidneys lose the ability to remove waste and balance fluids.) Review of Resident 400's admission record Inpatient Nephrology Consult Follow Up Note indicated, Resident 400 has left AV fistula and chest permacath (a flexible tube that's inserted into a blood vessel in the neck or chest). During a review of Resident 400's Blood Pressure Summary indicated, Resident 400 had the blood pressure taken on the left arm on the following dates: - 1/3/2025 at 02:00; - 1/3/2025 at 10:23; - 1/4/2025 at 09:05; - 1/5/2025 at 01:29; - 1/6/2025 at 09:32; - 1/7/2025 at 09:52; - 1/8/2025 at 10:11; - 1/10/2025 at 00:14; - 1/102025 at 16:20; - 1/11/2025 at 11:16; - 1/12/2025 at 05:29; - 1/12/2025 at 08:26; - 1/13/2025 at 08:34; - 1/14/2025 at 08:10; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 1/14/2025 at 12:45; - 1/14/2025 at 22:23; - 1/15/2025 at 10:13 and - 1/17/2025 at 08:21. During a concurrent interview and record review on 1/17/2025 at 11:41 a.m., with the Director of Nursing (DON), the DON reviewed Resident 400's clinical record and she stated, Resident 400 had chest permacath and left AV fistula. The DON confirmed, Resident 400's BP summary dated January 3,4,5,6,7,8,10,11,12,13, 14,15, and 17/2025, that were recorded were taken on left arm. The DON stated that nurses, should not check the blood pressure on the AV fistula, because it could interfere with the blood flow. Review of the facility's P&P titled Hemodialysis, Care of Residents, dated 11/2017, indicated, Standard . 4. Blood pressures or venous punctures will not be performed and physical restraint will not be applied on the extremity where access site is located.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27000 Based on observation, interview, and record review, the facility failed to ensure the adequate provision of pharmaceutical services when: 1. Three medications were not available for administration x 4 days, for one of 36 sampled residents (Resident 311). The failure had the potential for worsening and/or complications of the resident's medical conditions; and 2. Two of two nursing staff did not don appropriate personal protective equipment (PPE) during the preparation and administration of hazardous drugs (HDs; medications with potential to cause cancer and/or for causing other toxic effects on humans). The failure had the potential for staff and/or resident exposure to dangerous medications. Findings: 1. During a medication administration observation on 1/13/25 at 9:11 a.m., Licensed Vocational Nurse D (LVN D) was observed administering 3 medications, including an eye drop called Cosopt 2%-0.5% (medication to treat glaucoma) ophthalmic (eye) solution, to Resident 311. Upon review of Resident 311's clinical record, it indicated she was admitted to the facility on [DATE] with diagnoses including glaucoma and unspecified vision loss. The clinical record indicated the resident was to receive 3 eye medications, as follows: a. Cosopt ophthalmic solution 2%-0.5%, 1 drop in both eyes two times a day for glaucoma, dated 1/9/25; b. Vyzulta ophthalmic solution (to treat increased eye pressure in adults with ocular hypertension or open-angle glaucoma) 0.024%, 1 drop in both eyes two times a day for vision impairment, dated 1/9/25; and c. Xiidra ophthalmic solution (to treat signs and symptoms of dry eye disease) 5%, 1 drop in both eyes two times a day for vision impairment, dated 1/9/25. Resident 311 also had a physician's order for levothyroxine (medication to treat underactive thyroid gland) 75 micrograms, give 1 tablet daily in the morning for hypothyroidism, dated 1/9/25. On 1/13/25, a review of Resident 311's January 2025 Medication Administration Record (MAR) showed the resident had not been receiving the Vyzulta, Xiidra, and levothyroxine since 1/10/24 (or 4 days). During an interview with LVN D and Assistant Director of Nursing B (ADON B) on 1/13/25 02:11 p.m., ADON B stated the Xiidra and Vyzulta were put on hold (not administered) because I was told we don't have them available. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the nursing progress notes, from 1/9/25 to 1/13/25, indicated the nursing staff did not call or follow up with the pharmacy on the missing levothyroxine. For four consecutive days, from 1/10/25 to 1/13/25, the nursing staff wrote four times of Med in transit each day. For the Xiidra and Vyzulta eye drops, there was only one nursing notes, dated 1/10/25 at 22:36 (10:36 p.m.), indicating the nursing staff called the pharmacy and was told by a pharmacy staff that medication will arrive 1/11/25 with 5am medication run. There were no documentation of further follow-up with the pharmacy when these medications did not arrive on 1/11/25. During a follow-up interview with ADON B on 1/14/25 at 2:21 p.m., she stated she called the pharmacy and was told the Xiidra eye drop was not delivered because it was a high cost medication. ADON B confirmed the pharmacy should have communicated with the facility why it did not send the medication. ADON B was asked to find out the reason why the other two medications were not delivered. In a concurrent interview and record review with ADON B on 1/14/25 at 3:00 p.m., ADON B stated the facility faxed Resident 311's admission orders twice on 1/9/25 at 9:02 p.m. and again at 9:05 p.m., on the evening the resident was admitted . However, she showed an email from the pharmacy, dated 1/14/25, indicating: Investigation found that the 3 medications delayed til 1/13/25 were cut off on initial admit fax and pharmacy tech missed them on initial admit papers as a result . ADON B confirmed the facility staff should have followed up with the pharmacy each day they did not receive the medications for the resident. She also confirmed the 3 medications did not arrive until the afternoon of 1/13/25 (day of survey), and the resident did not receive them for 4 days. A review of the facility's policy and procedures (P&P) titled Pharmacy Services Overview, dated 4/2019, indicated: The facility shall accurately and safely . obtain pharmaceutical services, including the provision of routine and emergency medications . Residents have sufficient supply of the prescribed medications and receive medications .in a timely manner . Nursing staff communicate prescriber orders to the pharmacy and are responsible for contacting the pharmacy if a resident's medication is not available for administration. 2. During a medication administration observation with LVN D on 1/13/25 at 9:11 a.m., the 3 medications administered to Resident 311 included two tablets of megestrol (an anti-cancer medication that can also be used for loss of appetite) 40 milligrams (mg, unit of measurement). During the preparation, LVN D was observed punching 2 megestrol tablets from the blister pack (a card that packages doses of medication within small, clear plastic bubbles [or blisters]) into a small medication cup. Then she transferred them into a small plastic bag and crushed them into a fine powder using the crushing device. After finished, she transferred the crushed powder back into the medication cup and mixed it with applesauce. Observation of the pharmacy label revealed a dark red auxiliary label indicating: HAZARDOUS DRUGS. During this preparation process, LVN D did not wear gloves or had any special PPE. On 1/13/25 at 9:19 a.m., LVN D administered the medications to the resident with water. During an interview, on 1/13/25 at 9:29 a.m., when shown HAZARDOUS DRUGS sticker on the pharmacy label for megestrol tablets, LVN D stated she did not know if there was any special handling and administration procedures for HDs. During a follow-up interview on 1/13/25 at 11:17 a.m., LVN D stated she was supposed to wear gloves during handling and preparing HDs. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a medication administration observation with LVN J on 1/13/25 at 4:26 p.m., she was observed preparing and administering 3 medications, including 3 tablets of divalproex (medication to treat seizure or mood disorders) delayed release 125 mg, to Resident 25. The same dark red HAZARDOUS DRUGS sticker was affixed by the pharmacy label of the divalproex blister pack. LVN J did not wear gloves or had any special PPE for this preparation and administration. Shortly after the medication administration, on 1/13/25 at 4:37 p.m., when asked whether she should have worn special PPE when handling HDs, LVN J stated she did not know and I will need to ask the supervisor. During an interview with ADON B on 1/13/25 at 4:42 p.m., in the presence of LVN J, ADON B stated nurses should be wearing gloves when handling HDs. During an interview with the DON on 01/14/25 at 1:45 p.m., she stated the consultant pharmacist had given an in-service last year regarding handling and administering HDs. She stated, for HDs, The staff should handle more carefully by not touching them and wearing gloves during handling and administration. A review of the facility's P&P titled Policies and Procedures for the Safe handling of Hazardous Drugs, dated 10/3/2019, indicated, Hazardous Drugs may have special handling procedures in place that must be adhered to by all nursing staff that receive, handle, prepare, administer and destroy the HDs. It is the responsibility of all staff to know these procedures . and adhere to these policies and procedures when handling HD and Appropriate PPE must be worn when handling HDs including during . handling . preparation/mechanical manipulation . administration .

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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. 27000 Based on interview and record review, the facility failed to ensure one of 31 sampled residents (Resident 400) was free from unnecessary medications when there was no monitoring for signs and symptoms of bleeding while Resident 400 was receiving two medications with increased risk for bleeding: apixaban(an anticoagulant or blood thinner, to prevent blood clots) and clopidogrel (an antiplatelet medication which has potential to increase the risk of internal bleeding or gastrointestinal hemorrhaging). The failure resulted in inadequate monitoring, and had the potential for untimely recognition and intervention for adverse effects related to these medications. Findings: A review of Resident 400's clinical record indicated she was admitted to the facility with diagnoses including atrial fibrillation (an irregular and often very rapid heart rhythm, a condition that can lead to blood clots in the heart) and percutaneous coronary Intervention (PCI, a minimally invasive procedure used to open blocked coronary [heart] arteries that are narrowed or clogged by fatty deposits). A review of Resident 400's physician's orders included the following: - Eliquis (apixaban) 5 milligrams (mg, unit of measurement), 1 tablet by mouth two times a day for atrial fibrillation, dated 1/3/25; and - Clopidogrel 75 mg, 1 tablet by mouth one time a day for PCI, dated 1/3/25. A review of an online resource, www.drugs.com, it indicated, Using apixaban together with clopidogrel may increase the risk of bleeding, including severe and sometimes fatal hemorrhage (accessed 1/16/25). There was no documentation in Resident 400's clinical record indicating the nursing staff was monitoring for adverse effects (i.e. bleeding, bruising, etc) related to the use of apixaban and clopidogrel. A review of Resident 400's care plan, dated 1/2/25, indicated to monitor and report to the physician signs and symptoms of anticoagulant complications: blood tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, ,diarrhea, muscle joint pain, lethargy, bruising, blurred vision, SOB, loss of appetite, sudden changes in mental status, significant or sudden changes in v/s [vital signs]. During a concurrent interview and record review with the Director of Nursing (DON) on 1/16/25 at 2:26 p.m., she reviewed Resident 400's clinical and stated the monitoring for signs and symptoms related to anticoagulants should be monitored on the MAR [medication administration record]. She reviewed the resident's MAR and confirmed there was no monitoring for bleeding and other symptoms related to use of apixaban and clopidogrel. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled Anticoagulant, revised 9/2017, indicated, The staff and physician will monitor for possible complications in individuals who are being anticoagulated .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 27000 Based on interview and record review, the facility failed to ensure three out of 31 sampled residents (Residents 92, 307, and 400) were free from unnecessary psychotropic medications (drugs that affects brain activities associated with mental processes and behavior) when: 1. Resident 92 received four psychotropic medications without documented evidence of attempted or contra-indicated non-pharmacological (non-drug) interventions prior to initiating or increasing these medications. Also, there was no monitoring for side effects of aripiprazole (Abilify, an antipsychotic medication to treat mental illnesses) since July 2024; 2. Resident 307 received a PRN (as needed) prochlorperazine (antipsychotic medication which can be used for short term psychotic disorders or nausea/vomiting) without a 14-day limit; and 3. Resident 400 received trazodone (an anti-depressant medication) without effectiveness monitoring. The failures resulted in unnecessary medications for the residents, and had the potential for increased risks associated with psychotropic medication use that include but not limited to sedation, respiratory depression, falls, constipation, anxiety, agitation, abnormal involuntary movements, and memory loss. Findings: 1. A review of Resident 92's clinical record indicated she was admitted to the facility in June 2024 with diagnoses including anxiety and depression. A review of her physician's orders indicated, on 7/3/24, she received three new psychotropic medication orders, as follows: a. Aripiprazole (Abilify, an antipsychotic) 5 milligrams (mg, unit of measurement), give 1 tablet by mouth one time a day for Schizoaffective disorder Bipolar Type [a mental disorder with extreme highs (mania) and severe lows (depression)] for 1 Week m/b [manifested by] angry outburst, demeaning staff, calling staff names, cursing staff. b. Cymbalta (an antidepressant) 30 mg, give 1 capsule by mouth one time a day for depression m/b verbalization of sadness; and c. Clonazepam (an anti-anxiety medication) 0.5 mg, give 1 tablet two times a day for ANXIETY m/b verbalization of nervousness or expression of feeling panicky. Also, on the same day, 7/3/24, her trazodone (an antidepressant) was increased from 50 mg to 100 mg, to be administered at bedtime for depression m/b inability to sleep. (continued on next page)

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	056212	A. Building B. Wing	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Redwoods Post-Acute	1267 Meridian Avenue San Jose, CA 95125

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Despite the three new psychotropic medication orders and an increase in trazodone, there was no documented evidence in Resident 92's clinical record of attempted or contraindicated non-drug interventions prior to initiating and increasing these medications. Furthermore, there was no documented evidence the facility staff monitored for the side effects of aripiprazole since it was started. During a concurrent interview and record review with the Director of Nursing (DON) and Assistant DON C (ADON C) on 1/16/25 at 10:20 a.m., they reviewed Resident 92's clinical record and confirmed there had been no monitoring for the side effects of aripiprazole. The DON stated the side effects should be documented on the MAR but it was not there. During a follow-up interview with the DON on 1/16/25 at 3:58 p.m., she stated the non-drug interventions were documented only on the activity assessment and care plan but there was nothing documented to show non-drug interventions were implemented prior to starting the medications. 2. Resident 307 was admitted to the facility with diagnoses including depression, dysphagia (swallowing difficulties), and nasogastric (NG) tube (a small, flexible tube inserted through the nose and into the stomach for delivery of nutrition and medications) status. A review of Resident 307's clinical record indicated a physician's order, dated 1/6/25, for Prochlorperazine [an antipsychotic medication] .10 mg Give 1 tablet via NG-Tube every 8 hours as needed for Nausea or Vomiting. There was no 14-day limit to this order. During a concurrent interview and record review with the DON on 1/16/25 at 2:22 p.m., she confirmed there was no 14-day limit for Resident 307's prochlorperazine order. 3. A review of Resident 400's clinical record indicated she was admitted to the facility with diagnoses including insomnia (inability to sleep). On 1/3/25, she had a physician's order for trazodone 50 mg, 1 tablet by mouth at bedtime for insomnia m/b inability to sleep. During an interview with Resident 400 at her bedside on 1/16/25 at 8:40 a.m., Resident 400 stated she had not been sleeping well and would like to have stronger medication to help her sleep better. A review of Resident 400's January 2025 MAR indicated the nursing staff had been monitoring, since 1/2/25, for inability to sleep and placing a check mark for each shift; however, there was no monitoring for the hours of sleep (total amount of time the resident sleeps during a given period). During a concurrent interview and record review with the DON on 1/16/25 at 2:26 p.m., she reviewed Resident 400's MAR and stated the staff should be monitoring the hours of sleep in order to see whether the trazodone was effective in helping the resident sleep. A review of the facility's policy and procedures titled Psychotropic Medication Use, dated July 2022, indicated in part: Psychotropic medication management includes . adequate monitoring for efficacy and adverse consequences . (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications . PRN orders for psychotropic medications are limited to 14 days . For psychotropic medications that ARE antipsychotics: PRN orders cannot be renewed unless the attending physician or prescriber evaluates the resident and documents the appropriateness of the medication .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 27000 Based on observation, interviews, and record review, the facility had a medication error rate of 11.11% when three medication errors occurred out of 27 opportunities during the medication administration for three out of seven residents (Residents 81, 118, and 133). The failure resulted in the residents not receiving the medications as prescribed, and had the potential for complications such as unnecessary pain or medication side effects. Findings: 1. During the medication administration observation on 1/13/25 at 8:41 a.m., Licensed Vocational Nurse (LVN) D was observed preparing and administering 5 medications to Resident 81. The medications did not include a lidocaine patch (a topical medication applied to the skin for pain management). A review of Resident 81's clinical record indicated a physician's order, dated 11/26/24, for Lidocaine Patch 5% Apply to right shoulder topically one time a day for pain management. It was scheduled to be administered daily at 9 a.m. During an interview with LVN D on 1/13/25 at 2:09 p.m., she stated, We have only 4% but not 5% [patches]. We called pharmacy for delivery. She confirmed the patch was due this morning but it was not administered to the resident. A review of Resident 81's January 2025 Medication Administration Record (MAR) indicated a 4 (meaning other, see nurse notes') with LVN D's initials in the 1/13/25 at 9 a.m. entry for lidocaine 5% patch. A review of the nurse's notes, written on 1/13/2025 at 10:24 a.m. by LVN D, indicated: Lidocaine Patch 5 % . On order Call the the pharmacy, MD and family aware. Will fallow up with pharmacy. 2. During a medication administration observation on 1/13/25 at 10:08 a.m., LVN E was observed preparing 8 medications, including a lidocaine 4% patch, for Resident 133. On 1/13/25 at 10:26 a.m., at Resident 133's bedside, LVN E was observed removing a patch from the resident's left upper shoulder and applying the newly-prepared lidocaine 4% patch on the same location. During a concurrent interview and record review with LVN E on 1/13/25 at 10:30 a.m., she confirmed she removed the previous day's lidocaine patch before applying a new one. When asked whether the used patch should have been removed the night before, she reviewed Resident 133's clinical record and stated, They didn't remove at 9 p.m. but they were supposed to remove it. On 1/13/25 at 10:35 a.m., LVN E advised the surveyor, The resident refused to remove the patch. A review of Resident 133's clinical record indicated a physician's order, dated 12/24/24, for Lidocaine Patch 4% Apply to Left Shoulder topically one time a day for pain management Apply at 9am and remove at 9 pm. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/13/25, a review of the nursing progress notes, from 1/12 to 1/13/25, did not have any documentation regarding the resident refusing for the previous day's patch to be removed at 9 p.m. on 1/12/25. On 1/13/25 at 2:35 p.m., an interview was conducted with Resident 133 at his bedside with LVN E present. Resident 33 stated the staff had been applying the lidocaine patch daily in the morning and removing it at night. LVN E asked the resident why the one from last night was not removed, Resident 133 stated, I don't remember. LVN E asked whether he would be okay with them removing the patch tonight, he stated, Yeah, ok. I don't have a problem with that. 3. During a medication administration observation with LVN F on 1/13/25 at 10:36 a.m., she was observed preparing and administering 5 medications to Resident 118. Included in the medications was a tablet of aspirin chewable 81 milligrams (mg, unit of measurement). A review of Resident 118's clinical record indicated a physician's order for Aspirin EC [enteric coated - a coating formation that allows aspirin to pass through the stomach to the small intestine before dissolving] Low Dose Oral Tablet Delayed Release 81 mg Give 1 tablet by mouth one time a day for CVA ppx [cerebrovascular accident or stroke prevention]. During a concurrent interview and record review with LVN F on 1/13/25 at 2:26 p.m., she reviewed Resident 118's physician's order for aspirin and confirmed she administered the chewable (or immediate release) aspirin while the physician's order indicated for the enteric-coated, delayed release formulation. A review of the facility's policy and procedures titled Administering Medications, revised April 2019, indicated, Medications are administered in accordance with prescriber orders, including any required time frame.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50855 Based on observation, interview, and record review, the facility failed to ensure food safety and sanitation practices were maintained in the kitchen according to standards of practice and facility policy when two of the ceiling exhaust fans above the food preparation area were dirty and dusty with grey lint. These failures had the potential to cause food borne illness for 143 residents consuming food in the facility. Findings: During a kitchen tour observation on 1/13/25 at 1:58 p.m. two ceiling exhaust fans above the food preparation area were observed dirty and dusty with grey lint. During a concurrent observation and interview on 1/14/25 at 3:30 p.m., with the Maintenance Director (MDR), the MDR used the ladder to reach the ceiling exhaust fan above the food preparation area and wiped it, then he confirmed the dust. The MDR stated maintenance did the cleaning of the kitchen monthly. During a concurrent observation and interview on 1/14/25 at 3:35 p.m., with Registered Dietitian H (RD H), she confirmed two of ceiling exhaust fans above the food preparation area were dirty and dusty with grey lint. She stated that the food preparation area should be clean. She further stated, they would clean it before preparing the next meal. During a review of the facility's P&P titled Sanitization, Care of Residents revise date, 11/2022 indicated, 1. All kitchens, Kitchen areas and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects .

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 50855 Based on observation, interview, and record review, the facility failed to ensure one of two trash dumpsters had the lid closed completely. This failure had the potential to attract pests (like flies and rodents) that could spread diseases and bacteria to the 150 residents residing at the facility. Findings: During a concurrent observation and interview on 1/14/2025 at 3:24 p.m., with the Dietary Supervisor (DS), the lid of one trash dumpster behind the kitchen was open and not closed completely flat. The DS stated, that trash container lids should be closed completely. During a concurrent observation and interview on 1/14/2025 at 3:28 p.m., with the Maintenance Director (MDR), he confirmed, one of two trash dumpster's lid was not completely closed. The MDR stated all the facility garbage goes to those trash dumpsters. He stated, trash dumpster lid should be closed. During an interview on 1/16/2025 at 9:06 a.m., with the Infection Preventionist Nurse (IP), the IP stated that the trash dumpsters should be fully closed and should have no space in between the lid to prevent any animals from going in and to control the infection. During a review of the facility's policies and procedures (P&P) titled, Food-Related Garbage and Refused Disposal, Revised 10/2017, the P&P indicated . 2. All garbage and refuse containers are provided with tight-fitting lid or covers and must be kept covered when stored or not in continuous use . 5. Garbage and refuse containing food wastes will be stored in a manner that is inaccessible to pests .