STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056250	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherman Oaks Health & Rehab	14401 Huston St. Sherman Oaks, CA 91423

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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 - Few	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** 38552 Based on interview and record review, the facility failed to provide care in a manner that promoted dignity and respect for one of one sampled resident (Resident 115) when facility staff failed to follow the Do Not Resuscitate (DNR- a written document signed by the patient or their legal representative and the patient's physician, and it is placed in the patient's medical records indicating the resident's wishes of withholding resuscitation efforts) physician order for Resident 115 reviewed under Death care area. This deficient practice violated the rights of the resident to be treated with dignity and respect. Cross-reference: F678 Findings: During a review of Resident 115's Admission Record, the Admission Record indicated the facility originally admitted the resident on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (a condition where the brain does not work normally because of problems with the body's metabolism [how the body manages food, energy, or chemicals]), and sepsis (a life-threatening blood infection), and dementia (a progressive state of decline in mental abilities). During a review of Resident 115's Preferred Intensity of Care (PIC) Authorization/Decisions, dated [DATE], the PIC Authorization/Decisions indicated the resident's representative authorized no CPR and that the resident was not capable of making preferred intensity decisions and requested that the withholding of the above-described medical care was consistent with the views of the resident. During a review of Resident 115's History and Physical (H&P- a comprehensive assessment that involves a thorough medical history and a physical examination, forming the foundation for resident care and guiding diagnostic and treatment decisions), dated [DATE], the H&P indicated the resident did not have the capacity to understand and make decisions. The H&P indicated the resident did not want cardiopulmonary resuscitation (CPR-emergency procedure used to restart a person's heartbeat and breathing after one or both have stopped). (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 115's Minimum Data Set (MDS-a resident assessment tool), dated [DATE], the MDS indicated the resident had clear speech, moderately impaired vision, and was rarely/never makes self understood and rarely/never had the ability to understand others. The MDS indicated the resident had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. During a review of Resident 115's Change in Condition (COC-a major decline in the resident's status) Assessment Form, dated [DATE], the COC Assessment Form indicated the COC Assessment Form on [DATE] at 7:20 p.m., Resident 115 was found unresponsive and no vital signs (measurements of the body's most basic functions such as body temperature, heart [pulse] rate, respiration rate [rate of breathing], and blood pressure [pressure of circulating blood against the walls of blood vessels]) appreciated (no signs of life, such as a heartbeat, breathing, or movement, were detected or observed). The COC Assessment Form indicated chest compression was started, and code blue (a standardized alert system used to indicate a medical emergency, typically a person's heartbeat and breathing after one or both have stopped, requiring immediate resuscitation efforts) was announced. The COC Assessment Form indicated 911 (emergency telephone number) was called and paramedics arrived at the facility, relieved the licensed nurses, and continued to provide CPR to Resident 115 for another 25 minutes. The COC Assessment Form indicated at 7:50 p.m. CPR was stopped, and Resident 115 was pronounced expired. The COC Assessment Form indicated at 8 p.m. the resident's representative was notified. During a concurrent interview and record review on [DATE] at 9:46 a.m. with MDS Nurse (MDSN) 1, Resident 115's PIC Authorization/Decisions, dated [DATE] and physician orders were reviewed. MDSN 1 stated there was code/CPR status entered on the physician order in the resident's electronic health record. MDSN 1 stated the resident's PIC Authorization/Decisions form should have been reviewed by the social services with the resident's representative if they wanted any changes. MDSN 1 stated this should have been filed in the resident's current closed chart when he was readmitted on [DATE]. MDSN 1 stated it was filed in the resident's old chart with discharge date [DATE]. MDSN 1 stated this allows facility staff to know what the resident's preferred treatment is. MDSN 1 stated if this was not filed in the resident's current chart the resident could be considered full code status. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on [DATE] at 2:28 p.m. with the Social Services Director (SSD), Resident 115's PIC Authorization/Decisions, dated [DATE] and Social Service Note, dated [DATE], were reviewed. The SSD stated she documented that she informed the resident's representative that the resident will remain full code status until a Physician's Orders Life Sustaining Treatment (POLST- portable medical orders that communicate patient wishes for end-of-life intervention to health care facilities and providers, including emergency medical services) or an Advance Directive (AD-a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a physician). The SSD stated both POLST and AD are optional, and residents are not obligated to have unless they prefer to. The SSD stated when Resident 115 was readmitted to the facility on [DATE] and on [DATE] she did not see the PIC Authorization/Decisions form on the resident's chart, so she reached out to the resident's representative. The SSD stated she should have asked medical records to check on the resident's previous PIC Authorization/Decisions form. The SSD stated their facility's DNR policy and procedures (P&P) is to follow the DNR order unless the resident or resident's representative request to end the DNR order. The SSD stated when the resident's signed PIC Authorization/Decisions form was not filed on the resident's chart the resident will not receive their preferred care and their resident's rights of preferred treatment would not be followed and respected. The SSD stated POLST and AD acknowledgement form are done upon admission or the following day and Monday if the resident was admitted over the weekend. The SSD stated Resident 115 had a COC on [DATE] where the resident was found unresponsive with no vital signs were appreciated and CPR was administered. The SSD stated she missed it and the resident received CPR who had a DNR order. During an interview on [DATE] at 3:07 p.m. with the Director of Nursing (DON), the DON stated the resident's/resident's representatives are not required to complete the POLST or an advance directive are optional. The DON stated what the residents or resident's representative fills out is the advance directive acknowledgement form (document provided by the facility that indicates whether a resident has an advance directive, would like information regarding creation of an advance directive, or refusal to create an advance directive) which would indicate the resident's preferred intensity of care. The DON stated it is very important to follow upon the resident's admission and ask the medical record staff to bring up the resident's preferred intensity of treatment in the new chart because it reflects the resident's wishes. The DON stated if the resident/resident's representative does not have one they can offer and make a new preferred intensity of care. The DON stated this should have been done as soon as possible if the resident was admitted on the weekend either the next day or go by the code status order from the hospital record. During a review of the facility's P&P titled, Resident Rights, last reviewed [DATE], the P&P indicated employees shall treat all residents with kindness, respect, and dignity. The P&P indicated These rights include the resident's right to: a. dignified existence; b. be treated with respect, kindness, and dignity; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Do Not Resuscitate Order, last reviewed [DATE], the P&P indicated the facility will not use cardiopulmonary resuscitation and related emergency measures to maintain life functions on a resident when there is a Do Not Resuscitate Order in effect. The P&P indicated Do Not Resuscitate orders must be signed by the resident's attending physician on the physician's order sheet maintained in the resident's medical record. The P&P indicated DNR orders will remain in effect until the resident (or legal surrogate) provides the facility with a signed and dated request to end the DNR order. During a review of the facility's P&P titled, POLST, last reviewed [DATE], the P&P indicated Just because POLST is offered does not mean the resident or legal representative must complete one. No one is required to complete a POLST form as it is 100% voluntary.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 3. During a review of Resident 48's Admission Record, the Admission Record indicated the facility originally admitted the resident on 4/27/2024 and readmitted in the facility on 1/29/2025 with diagnoses including major depressive disorder, congestive heart failure (CHF - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and generalized weakness. During a review of Resident 48's H&P dated 1/30/2025, the H&P indicated Resident 48 had the capacity to understand and make decisions. During a review of Resident 48's MDS, dated [DATE], the MDS indicated Resident 48 had an intact cognition and required supervision or touching assistance with eating and oral hygiene, partial/moderate assistance with upper body dressing, and substantial/maximal assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS further indicated Resident 48 antidepressant and hypnotic (a class of psychoactive medicines [medications that affect the brain and can change how you think, feel, perceive, and behave, and are often used to treat mental health conditions] to induce sleep). During a review of Resident 48's Order Summary Report, the Order Summary Report indicated the following physician's orders dated 1/29/2025: - trazodone hydrochloride oral tablet 50 mg give 1 tablet by mouth at bedtime for depression manifested by expression of sadness. - temazepam oral capsule 15 mg give 1 capsule by mouth as needed at bedtime for insomnia manifested by inability to sleep or sleeplessness for 14 days document non-pharmacological interventions (NPI):1 for rest/reposition, 2 for cues/prompt/reassure, 3 for redirection/diversion/re-orientation, or 4 for other. Document result or effectiveness of NPI: E if effective, or N for non-effective. During a review of Resident 48's care plans (CP), the CPs indicated the following: 1. Antidepressant - Resident 48 has episodes of depression manifested by expression of sadness initiated on 1/12/2026 and last revised on 3/8/2025, the CP indicated to administer medication as ordered and observe for side effects and document occurrence of side effects as a few of the interventions to minimize risk of adverse side effects of medication use and behavior episodes daily. 2. Sedative/hypnotic - Alteration in sleep patterns initiated on 1/12/2025 and last revised on 1/30/2025, the CP indicated to administer medications as ordered and observe for side effects and document occurrence of side effects as a few of the interventions to minimize risk of adverse side effects of medication use and behavior episodes daily. During a review of Resident 48's Informed Consent form for the use of trazodone hydrochloride and temazepam dated 1/30/2025, the Informed Consent did not indicate Resident 48's signature and/or the resident's representative giving consent for the use of trazodone hydrochloride and temazepam and the physician's signature. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/14/2025 at 9 a.m., reviewed Resident 48's Informed Consent and physician's order with Registered Nurse (RN) 1. RN 1 stated Resident 48 had a physician's order for trazodone hydrochloride and temazepam. RN 1 stated the informed consents were not complete and did not indicate Resident 48's signature and/or the resident's representative consenting to the use of trazodone hydrochloride and temazepam. RN 1 stated the form did not indicate the signature of the physician who obtained the consent. RN 1 stated consents are obtained by the physician from the resident and/or their representative upon admission or when the medication was ordered to explain the risks and benefits and give them the option to refuse or accept the treatment. RN 1 stated licensed nurses are then supposed to confirm with the physician prior to obtaining the signature from the resident and/or representative. RN 1 stated Resident 48's Informed Consent should have been signed by the physician and the resident and/or their representative should have signed the informed consents as the medications have side effects and needs to be consented prior to starting the medications. RN 1 stated the deficient practice placed Resident 48 and/or the representative for not being aware of the risks and benefits of the antidepressant and hypnotic and an opportunity to decline or accept the proposed treatment. During an interview on 3/14/2025 at 11:37 am with the DON, the DON stated it was important to ensure the consent was accurately and completely filled out by the licensed staff to ensure the family or the resident was agreeable with the use of the medications. The DON stated the physician needs to explain the risks and benefit to the resident and/or representative and why the medication is needed. The DON stated the doctor is supposed to get the consent and explain the risks and benefits of the medication and the RN will follow up and confirm if the doctor has spoken to the resident and/or their representative. The DON stated the physician should have signed Resident 48's informed consent form for the use of trazodone hydrochloride and temazepam to ensure Resident 48 and/or her representative were aware of the risks and benefits of the medication and give them the opportunity to refuse or accept the treatment. During a review of the facility's recent P&P titled Informed Consent, last reviewed on 9/27/2024, the P&P indicated: - Prior to prescribing a psychotherapeutic medication, the licensed practitioner shall examine the resident and obtain informed consent either from the resident (if able) or the resident's representative. - The licensed nurse shall verify informed consent specifying the disclosure of material information for proper informed consent which includes: i. Possible non-pharmacological approaches that could address the resident's needs. ii. Whether the drug has current black box warning label along with summary of, and information about how to find, the contraindications, warning, and precautions required by the US Food and Drug Administration (FDA). iii. Whether the proposed medication has or has not been approved by the US FDA. iv. Possible interactions with other drugs the resident is/are receiving. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 8's Informed Consent form for divalproex sodium, dated 2/14/2025, the Informed Consent form indicated the document was to be completed before treatment is initiated with psychotherapeutic drugs. The form was blank in the space provided for the resident/resident representative's signature. The form was blank in the space provided for the physician/prescriber's signature. During a review of Resident 8's Informed Consent form for sertraline, dated 2/14/2025, the Informed Consent form indicated the document was to be completed before treatment is initiated with psychotherapeutic drugs. The form was blank in the space provided for the resident/resident representative's signature. The form was blank in the space provided for the physician/prescriber's signature. During a concurrent interview and record review on 3/13/2025 at 11:21 a.m. with Minimum Data Set Nurse (MDSN) 1, MDSN 1 reviewed Resident 8's physician orders, Informed Consent form for sertraline dated 2/14/2025, and Informed Consent form for divalproex sodium dated 2/14/2025. MDSN 1 stated psychotropic medications are used to treat behavioral issues and have a risk of side effects like dizziness. MDSN 1 stated it was important to obtain informed consent to ensure residents and family members are aware of the risks of taking the medications. MDSN 1 state the process when a resident takes a psychotropic medication is the physician obtains informed consent from the resident/resident representative and consent is documented on the Informed Consent form before the medication is administered. MDSN 1 stated Resident 8 was administered sertraline three times a day and divalproex sodium daily for anger and there was no documented evidence that the physician had obtained informed consent from Resident 8's representative. MDSN 1 stated when consent was not obtained it could have potentially resulted in psychotropic medication administered without the family's consent resulting in side effects of unnecessary medications that may lead to injury from falls. During a concurrent interview and record review on 3/13/2025 at 1:11 p.m. with the DON the DON reviewed Resident 8's physician orders, Informed Consent form for sertraline dated 2/14/2025, and Informed Consent form for divalproex sodium dated 2/14/2025. The DON stated it is important that the physician explains the side effects of psychotropic medication so the resident and representatives may consider the risks verse the benefits of psychotropic medication in order to make an informed decision. The DON stated there was no documented evidence that the physician obtained informed consent regarding Resident 8's sertraline or divalproex sodium. The DON stated if it was not documented then it was not done. The DON stated when the physician did not obtain consent from Resident 8's representative it could have potentially resulted in Resident 8's representative not being able to exercise their right to refuse or accept medications and Resident 8 being administered psychotropic medications against the family's wishes. The DON stated the facility policy was not followed. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Informed Consent, last reviewed 9/27/2024, the P&P indicated it was the policy of the facility to involve residents in their care decisions by facilitating information and obtaining consent for the use of psychotropic drugs. Psychotropic drugs are any drug that affects brain activities associated with mental processes and behavior. These drugs include but are not limited to drugs in the following categories: antipsychotic, anti-depressants, anti-anxiety, and hypnotic. The licensed provider will obtain an informed consent for the use of psychotropic drugs from the resident or legal representative. When a new order for the use of psychotherapeutic medication is made, the licensed nurse shall verify whether informed consent was obtained and document the verification process in the resident's clinical record on the Informed Consent form. Licensed nurse shall verify from the Resident and/or legal representative whether the consent has been obtained for the use of prescribed psychotherapeutic medication and will sign the form and document the name of the person who gave consent and the date when the consent was verified. During a review of the facility's P&P titled, Psychotropic Medication Use, last reviewed 9/27/2024, the P&P indicated residents (and/or representatives) have the right to decline treatment with psychotropic medications. 44376 Based on interview and record review, the licensed nursing staff failed to ensure the residents and/or responsible party (RP) were informed in advance, of the risks and benefits of psychoactive medication (psychotropic medication, psychotherapeutic medication - a drug that changes brain function and results in alterations in perception, mood, consciousness or behavior) for four of five sampled residents (Residents 96, 89, 48, and 8) reviewed for informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) by failing to ensure: 1. Resident 96's sertraline (treat the symptoms of depression [persistent feelings of sadness and loss of interest that can interfere with daily living]) or other mental health problems) and alprazolam (drug used to treat anxiety disorders [a feeling of worry, nervousness, or fear, often about things that might happen, and it can involve physical symptoms like a racing heart or sweating] and panic attacks) informed consents: a. Indicated if the resident consented to its use; b. Indicated the prescribing physician obtained informed consent from the resident or representative and explained the risk and benefits of its use; c. Indicated the licensed nurse confirmed and verified with the resident or representative if they consented to the use of the psychoactive medication by indicating in the informed consent who consented for its use. 2. Resident 89's quetiapine (treats schizophrenia [symptoms that included a blunting of emotions and a lack of motivation] and bipolar disorder [a mental health condition that causes extreme mood swings]) had an informed consent prior to its use. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. a. Resident 48 and/or the legal representative was/were provided informed consent for the use of trazodone hydrochloride (a medication used to treat depression and temazepam (a medication used to treat trouble with sleeping). b. The prescribing physician signed the consent. 4. Resident 8's use of sertraline (a psychotropic medication used to treat depression and divalproex sodium (a psychotropic medication used to treat severe mood swings) had an informed consent. These deficient practices had the potential to result in the use of unnecessary psychotropic drugs and adverse effects (an undesired and harmful result of a treatment or intervention, such as a medication or surgery) of the medication. Findings: 1. During a review of Resident 96's Admission Record, the Admission Record indicated the facility admitted the resident on 3/6/2024, and readmitted the resident on 2/3/2025, with diagnoses including anxiety disorder, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 96's History and Physical (H&P), dated 2/5/2025, the H&P indicated the resident was alert and oriented to person, place, time, and situation. During a review of Resident 96's Minimum Data Set (MDS, a resident assessment tool), dated 2/10/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (someone's thinking, memory, and other mental processes are functioning normally, without any significant impairments or problems). The MDS indicated the resident was on an antianxiety (drugs used to reduce feelings of worry, fear, and nervousness, helping people manage anxiety symptoms or disorders) and antidepressant medications (a type of medicine used to treat clinical depression). During a review of Resident 96's Order Summary Report, dated 2/3/2025, the Order Summary Report indicated physician orders for: - Alprazolam oral tablet 0.5 milligrams (mg, a unit of weight). Give 1 tablet by mouth at bedtime for anxiety monitor for behavior (MB) panicky feelings causing stress. - Sertraline hydrochloride (hcl) oral tablet 50 mg (sertraline hcl). Give 1 tablet by mouth one time a day for major depressive disorder MB persistent feelings of hopelessness/helplessness. During a review of Resident 96's Informed Consent on the use of sertraline 50 mg, dated 2/3/2025, the Informed Consent did not indicate who the prescriber spoke with to explain the risk and benefits of taking the medication and if the resident or representative consented to its use. The licensed nurse who was tasked to double check if the resident was educated on the risk and benefits of taking the medication did not complete the missing information on the Informed Consent Form. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 96's Informed Consent on the use of alprazolam 0.5 mg, dated 2/3/2025, the Informed Consent did not indicate who the prescriber spoke with to explain the risk and benefits of taking the medication and if the resident or representative consented to its use. The licensed nurse who was tasked to double check if the resident was educated on the risk and benefits of taking the medication did not complete the missing information on the Informed Consent Form. The Informed Consent also indicated the medication was used if needed (PRN) at night (HS) while the prescriber's order indicated to give 1 tablet by mouth one time a day for major depressive disorder MB persistent feelings of hopelessness/helplessness. During a concurrent interview and record review on 3/12/2025, at 8:35 a.m., with Registered Nurse (RN) 1, reviewed the Informed Consents of Resident 96. RN 1 stated the Informed Consents for alprazolam and sertraline were incomplete, there was no signature of the doctor, no signature of the resident or resident representative if they consented to its use and the physician has not confirmed that he has given the information to the resident about the risk and benefits of taking the medication. The licensed nurse signed but unclear if she spoke to the resident or representative as it is not indicated on the form. RN 1 stated they should complete the Informed Consent forms for resident using psychoactive medications to ensure the resident or representative were educated on the risk and benefits of using the psychoactive drugs and honor the resident's right to agree or disagree with the proposed treatment. During an interview on 3/14/2025, at 11:37 a.m., with the Director of Nursing (DON), the DON stated Resident 96's Informed Consents on the use of alprazolam and sertraline should have been accurately completed by the prescribing doctor and licensed nurses to ensure the resident consented to its use. The prescribing doctor explains the risk and benefits of taking the psychoactive medications and the licensed nurses will follow up if the resident or resident representative consented to its use. The DON stated every time there is an increase in the dosage of psychoactive medication prescribed to the resident, a new Informed Consent should be obtained. The DON stated the failure of the staff to accurately complete the form denied the residents of their rights to informed care. During a review of the facility's recent policy and procedure (P&P) titled Informed Consent, last reviewed on 9/27/2024, the P&P indicated prior to prescribing a psychotherapeutic medication, the licensed practitioner shall examine the resident and obtain informed consent either from the resident (if able) or the resident's representative. The Licensed nurse shall verify informed consent specifying the disclosure of material information for proper informed consent which includes: i. Possible non-pharmacological approaches that could address the resident's needs ii. Whether the drug has current black box warning label along with summary of, and information about how to find, the contraindications, warning, and precautions required by the US Food and Drug Administration (FDA) iii. Whether the proposed medication has or has not been approved by the US FDA. iv. Possible interactions with other drugs the resident is/are receiving. v. How the facility and the prescriber will monitor and respond to any adverse side effects and inform of side effects (if any). (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Licensed nurse shall verify from the resident and/or legal representative whether the consent had been obtained for the use of prescribed restraint(s) and/or psychotherapeutic medication and will sign the form and document the name of the person who gave consent and the date when the consent was verified. The licensed prescriber, resident or representative may sign the informed consent using remote technology, if possible and as soon as practicable. The facility shall renew the written informed consent for the prescribed psychotropic/psychotherapeutic drug regimen every six months and as needed when there is an increase on medication dosage. During a review of the facility's recent P&P titled Psychotropic Medication Use, last reviewed on 9/27/2024, the P&P indicated residents (and/or representatives) have the right to decline treatment with psychotropic medications. a. The staff and physician will review with the resident/representative the risks related to not taking the medication as well as appropriate alternatives. 2. During a review of Resident 89's Admission Record, the Admission Record indicated the facility admitted the resident on 2/17/2023, with diagnoses including major depressive disorder, mood disorder (a mental health condition that primarily affects your emotional state), and dementia (a progressive state of decline in mental abilities). During a review of Resident 89's H&P, dated 2/28/2025, the H&P indicated the resident was alert and oriented to person only and does not have the capacity to understand and make decisions. During a review of Resident 89's MDS, dated [DATE], the MDS indicated the resident usually had the ability to make self-understood and understand others and had moderate cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident was on a high-risk drug class antipsychotic (drugs that mainly treat psychosis-related conditions and symptoms) and antidepressant medications. During a review of Resident 89's Order Summary Report, dated 12/9/2023, the Order Summary Report indicated an order of quetiapine fumarate oral tablet 50 mg. Give 50 mg by mouth at bedtime for psychosis MB inability to process external stimuli anger. During a concurrent interview and record review on 3/12/2025, at 9:02 a.m., with RN 1, reviewed the Informed Consents of Resident 89. RN 1 stated there was no Informed Consent for quetiapine fumarate oral tablet 50 mg. During a concurrent interview and record review on 3/13/2025, at 11:24 a.m., with RN 1, reviewed the Informed Consent of Resident 89 for seroquel 25 mg orally (PO) every night (q HS). RN 1 stated the medication was increased to 50 mg, but the licensed staff did not obtain a consent for the increase in dosage. RN 1 stated they should have obtained a new consent for the increase in the seroquel's dosage to ensure the resident still agrees to its use and to make sure the resident understands the risk and benefits of taking the medication. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/14/2025, at 11:37 a.m., with the DON, the DON stated the licensed nurses should have obtained a new Informed Consent on the use of quetiapine fumarate oral tablet 50 mg. The DON stated every time there is an increase in the dosage of psychoactive medication prescribed to the resident, a new Informed Consent should be obtained. The DON stated the failure of the staff to accurately complete the form denied the residents of their rights to informed care. During a review of the facility's recent P&P titled Informed Consent, last reviewed on 9/27/2024, the P&P indicated prior to prescribing a psychotherapeutic medication, the licensed practitioner shall examine the resident and obtain informed consent either from the resident (if able) or the resident's representative. The licensed nurse shall verify informed consent specifying the disclosure of material information for proper informed consent which includes: i. Possible non-pharmacological approaches that could address the resident's needs ii. Whether the drug has current black box warning label along with summary of, and information about how to find, the contraindications, warning, and precautions required by the US Food and Drug Administration (FDA) iii. Whether the proposed medication has or has not been approved by the US FDA. iv. Possible interactions with other drugs the resident is/are receiving. v. How the facility and the prescriber will monitor and respond to any adverse side effects and inform of side effects (if any). Licensed nurse shall verify from the resident and/or legal representative whether the consent had been obtained for the use of prescribed restraint(s) and/or psychotherapeutic medication and will sign the form and document the name of the person who gave consent and the date when the consent was verified. The Licensed prescriber, Resident or representative may sign the informed consent using remote technology, if possible and as soon as practicable. The facility shall renew the written informed consent for the prescribed psychotropic/psychotherapeutic drug regimen every six months and as needed when there is an increase on medication dosage. During a review of the facility's recent P&P titled Psychotropic Medication Use, last reviewed on 9/27/2024, the P&P indicated residents (and/or representatives) have the right to decline treatment with psychotropic medications. b. The staff and physician will review with the resident/representative the risks related to not taking the medication as well as appropriate alternatives.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44244 Based on observation, interview, and record review the facility failed to provide reasonable accommodation of resident needs and preferences by failing to ensure the call light (CL, an alerting device for nurses or other nursing personnel to assist a patient when in need) was within reach for two of six sampled residents (Residents 46 and 107) reviewed under the Environment task. This deficient practice had the potential to result in the delay of care and services and possible injury to residents when they are unable to summon health care workers. Findings: a. During a review of Resident 46's Admission Record, the Admission Record indicated the facility admitted the resident on 3/25/2022 and readmitted the resident on 6/12/2023 with diagnoses that included dysphagia (difficulty swallowing) unspecified cerebrovascular disease (conditions that affects blood vessels and blood supply of the brain), sequelae (a condition which is the consequence of a previous disease or injury) of nontraumatic subarachnoid hemorrhage (a type of stroke caused by bleeding in the brain), dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that interfere with daily life), and history of falling. During a review of Resident 46's Minimum Data Set (MDS - resident assessment tool), dated 12/18/2024, the MDS indicated the resident rarely/never was able to understand others and rarely/never was able to make himself understood. The MDS further indicated Resident 46 had impairment on both sides of the lower extremities, was dependent on staff for toileting, bathing, personal and oral hygiene, dressing, and mobility. During a review of Resident 46's History and Physical (H&P), dated 7/2/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 46's Order Summary Report, the report indicated the following orders: -Place the resident on the falling star program (interventions to reduce the occurrence of falls) related to high-risk score on the fall risk assessment, dated 1/8/2025. -Low bed with bilateral (both sides) upper (located at the chest and shoulders) siderails (adjustable rigid plastic bars attached to the bed that may be positioned in various locations) up when in bed to decrease the potential injury due to unpredictable movement related to dementia, dated 11/21/2024. During a review of Resident 46's Care Plan (CP) titled, Resident is at risk for falls related to: history of fall prior to admission, aging process, limited mobility, unsteady balance, poor safety awareness, cognitive and communication impairment, vision impairment ., initiated 6/13/2023 and last revised 1/10/2025, the CP indicated to keep the call light within easy reach and encourage the resident to use it to get assistance. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/11/2025 at 9:30 a.m., Resident 46 was lying in bed. Resident 46 did not respond to the surveyor. Observed the CL device and cord were hanging from a hook on the wall. Observed the CL was not within reach of Resident 46 lying in bed and no staff were present in the room. During a concurrent observation and interview on 3/11/2025 at 9:32 a.m., with the Infection Preventionist (IP), the IP entered Resident 46's room and stated the CL should be within Resident 46's reach for dignity reasons and for Resident 46 to call for staff when there is a need. The IP stated Resident 46's CL was hanging on the wall, but it should have been within reach of the resident and was not. The IP stated about twenty minutes prior, the IP assisted with providing care to Resident 46 and it was an oversight that the CL was not placed back within reach of the resident prior to exiting the room. The IP stated Resident 46 does not move, but the CL should always be within reach because Resident 46 may be able to use the CL at some point, and the CL should be within reach. During a concurrent interview and record review on 3/14/2025 at 9:35 a.m., with the Director of Nursing (DON), the DON reviewed the facility's policy and procedures regarding CLs. The DON stated it was important for residents to have a CL to be able to call for staff to immediately attend to residents when help is needed. The DON stated the CL should be within reach of all residents, including the residents that are not able to move. The DON stated a resident may have a change of condition and be able to use the CL. The DON stated the facility policy was not followed when Resident 46's CL was not within reach. The DON stated when the CL was not within reach, there was a potential that staff may not be aware of a change of condition in the resident resulting in a delay in care. During a review of the facility's policy and procedure (P&P) titled, Answering the Call Lights, last reviewed 9/27/2024, the P&P indicated the purpose of the policy was to ensure timely responses to the resident's requests and needs. Ensure the CL is accessible to the resident when in bed. During a review of the facility P&P titled, Resident Rights, last reviewed 9/27/2045, the P&P indicated employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of the facility. These rights include the residents right to communication with and access to people and services, both inside and outside the facility. 44376 b. During a review of Resident 107's Admission Record, the Admission Record indicated the facility admitted the resident on 2/17/2025, with diagnoses including lack of coordination, difficulty in walking, and presence of automatic cardiac defibrillator (a portable device that can be used to treat a person whose heart has suddenly stopped working). During a review of Resident 107's H&P, dated 2/19/2025, the H&P indicated the resident was alert and oriented to person, place, and time. The H&P indicated the resident had the capacity to understand and make decisions. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 107's MDS dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others, and had intact cognition (a participant who has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). The MDS indicated the resident required partial to supervision assistance on mobility and activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a concurrent observation and interview on 3/11/2025 at 9:55 a.m., with the Assistant Director of Staff Development (ADSD), inside Resident 107's room, observed the call light was resting on the floor at the right side of the resident's bed. The ADSD stated the call light should always be within the reach of the resident so they can call for help when needed. During an interview on 3/13/2025, at 10:31 a.m., with Registered Nurse (RN) 1, RN 1 stated the call light of Resident 107 should always be within reach so that the resident can call for help when needed. RN 1 stated if the call light keeps on falling off the bed, the staff can clip them on the bed sheet to keep them off the floor. RN 1 stated as soon as the staff sees the call light is on the floor, the staff should disinfect them before placing them within the residents reach to prevent infection. RN 1 stated there is a potential for residents to fall reaching for the call light on the floor, and it can be a trip hazard for the residents and staff too. During an interview on 3/14/2025, at 11:37 a.m., with the Director of Nursing (DON), the DON stated Resident 107's call light should always be within reach so that if there is an emergency on the part of the resident, they can call right away. The DON stated there is a potential for Resident 107 to fall while reaching for the call light on the floor. The DON added it is the responsibility of all staff in the facility to ensure resident's call lights are withing reach. During a review of the facility's recent P&P titled Answering the Call Light, last reviewed on 9/27/2024, the P&P indicated the purpose of this procedure is to ensure timely responses to the resident's requests and needs. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor. During a review of the facility's recent P&P titled Accommodation of Needs, last reviewed on 9/27/2024, the P&P indicated our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity and well-being. e. installing longer cords or providing remote controlled overhead or task lighting so that they are easily accessible.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 43988 Based on observation, interview, and record review, the facility failed to promote the resident rights to examine the results of the most recent survey (a survey to determine compliance with state and federal regulations) of the facility by failing to post the most recent survey results in places that are prominent and accessible (a place where individuals wishing to examine survey results do not have to ask to see them) to residents, family members, and legal representatives of residents. This deficient practice resulted in the residents' and their representative not having access to examine the most recent survey results. Findings: During an interview on 3/12/2025 at 10:03 a.m., inside the dining room, seven (7) of 7 resident council group attendees stated they do not know where to examine the most recent survey results. The attendees pointed at the black metal rack outside the Activity Director's (AD) office where they can locate the binder for the most recent survey results. During a concurrent observation, upon inspection of the black metal rack, there was no survey binder available. During a concurrent observation and interview on 3/12/2025 at 10:43 a.m., in the lobby with the AD. The AD stated the survey binder is placed on the table outside the social services and admissions office. The AD stated the binder was placed flat and located underneath the tabletop's surface and did not have a visible sign posted. The AD stated the survey binder was previously placed on top of the counter and corded because some residents take it and at night and write on the papers. Upon inspection, the survey did not have the most recent recertification survey results from 2024. During a concurrent observation and interview on 3/12/2024 at 10:46 a.m. in the lobby with the Administrator (Adm), the Adm stated the State inspection results should be available for all residents and/or their representatives, so residents/resident representatives know what the facility is working on. The Adm stated the survey result should be readily accessible. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, last reviewed on 9/27/2024, the P&P indicated the resident rights include the resident's right to examine survey results. The P&P further indicated a copy of the most recent standard survey is maintained in a three-ring binder located in an area frequented by most residents, such as the main lobby or resident activity room.

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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** 43988 Based on interview and record review, the facility failed to offer the resident or their resident representative assistance with formulating an Advance Directive (AD - a legal document indicating resident preference on end-of-life treatment decisions) upon admission for two of two sampled residents (Residents 79 and 97) reviewed for advance directive. This deficient practice violated the residents and/or their representatives the right to be fully informed of the option to formulate an AD and had the potential to delay emergency treatment or the potential to force emergency, life-sustaining procedures against the residents' personal preferences. Findings: a. During a review of Resident 79's Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/29/2024 and readmitted in the facility on 9/17/2024 with diagnoses including dementia (a progressive state of decline in mental abilities), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness of the arm, leg, and trunk on the same side of the body) following cerebral infarction (also known as stroke, loss of blood flow to a part of the brain) affecting left non-dominant side. During a review of Resident 79's History and Physical (H&P), dated 9/18/2024, the H&P indicated Resident 79 did not have the capacity to understand and make decisions. During a review of Resident 79's Minimum Data Set (MDS, a resident screening tool), dated 2/5/2025, the MDS indicated Resident 79 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required substantial/maximal assistance to total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 79's Preferred Intensity of Care Surrogate Decision Maker Form, dated 9/18/2024, the Preferred Intensity of Care Surrogate Decision Maker Form did not indicate the resident was asked for a presence of an AD and/or was offered assistance in the formulation of an AD. The form indicated Resident 79 is not capable of making preferred intensity of care decisions at this time. During a review of Resident 79's Interdisciplinary Team (IDT - a group of health care professionals with various areas of expertise who work together toward the goals of their patients) Madwords Form, dated 9/25/2024, the IDT Madwords Form did not indicate Resident 79's representative was asked if the resident had an AD. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/12/2025 at 9:16 a.m., reviewed Resident 79's Preferred Intensity of Care Surrogate Decision Maker Form and IDT Madwords with the Social Services Director (SSD). The SSD stated Resident 79's Preferred Intensity of Care Surrogate Decision Maker Form did not indicate Resident 79's representative was asked if the resident had an AD and/or was offered assistance in the formulation of an AD. The SSD stated the IDT discussed during the care conference with Resident 79's representative the AD but the IDT Madwords Form did not indicate if Resident 79's representative was asked for the presence and/or assistance was provided in the formulation of an AD. The SSD stated the IDT should have asked Resident 79's representative if the resident had a written AD or provide assistance in the formulation of an AD. The SSD stated it was important for the AD to be in Resident 79's medical record to ensure there is no delay in the care and services the resident needed in the event of an emergency and to ensure the facility is respecting Resident 79's wishes in case of an emergency. During a concurrent interview and record review on 3/13/2025 at 10:30 a.m., reviewed Resident 79's Preferred Intensity of Care Surrogate Decision Maker Form with Registered Nurse (RN) 1. RN 1 stated Resident 79's Preferred Intensity of Care Surrogate Decision Maker Form did not indicate Resident 79's representative was asked if the resident had an AD and/or was offered assistance in the formulation of an AD. RN 1 stated the SSD is responsible in asking the residents and/or their representative if the resident had executed an AD and will be offered assistance to formulate an AD if needed and documented in the medical record. RN 1 stated the SSD should have asked Resident 79's representative for the presence of an AD and/or offer assistance in the formulation if needed. RN 1 stated it was important for the AD information to be in Resident 79's medical record to ensure there is no delay in the provision of necessary care and services in the event of an emergency and to ensure the facility is honoring Resident 79's wishes in case of an emergency. b. During a review of Resident 97's Admission Record, the Admission Record indicated the facility admitted the resident on 6/26/2024 with diagnoses including Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (a mental health condition characterized by persistent and intense feelings of worry, fear, and apprehension). During a review of Resident 97's H&P, dated 7/2/2025, the H&P indicated Resident 97 did not have the capacity to understand and make decisions. During a review of Resident 97's MDS, dated [DATE], the MDS indicated Resident 97 had severely impaired cognition and required substantial/maximal assistance to total assistance from staff with all ADLs. During a review of Resident 97's Preferred Intensity of Care Surrogate Decision Maker Form dated 7/18/2024, the Preferred Intensity of Care Surrogate Decision Maker Form did not indicate the resident was asked for a presence of an AD and/or was offered assistance in the formulation of an AD. The form indicated Resident 97 is not capable of making preferred intensity of care decisions at this time. During a review of Resident 97's Interdisciplinary Team (IDT - a group of health care professionals with various areas of expertise who work together toward the goals of their patients) Madwords Form dated 7/25/2024, the IDT Madwords Form did not indicate Resident 97's representative was asked if the resident had an AD. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/12/2025 at 8:35 a.m., reviewed Resident 97's Preferred Intensity of Care Surrogate Decision Maker Form and IDT Madwords with the Social Services Director (SSD). The SSD stated Resident 97's Preferred Intensity of Care Surrogate Decision Maker Form did not indicate Resident 97's representative was asked if the resident had an AD and/or was offered assistance in the formulation of an AD. The SSD stated the IDT discussed during the care conference with Resident 97's representative the AD but the IDT Madwords Form did not indicate if Resident 97's representative was asked for the presence of and/or assistance was provided in the formulation of an AD. The SSD stated she should have asked Resident 97's representative if the resident had a written AD or provide assistance in the formulation of an AD. The SSD it was important for the AD to be in Resident 97's medical record to ensure there is no delay in providing the care and services the resident needed in the event of an emergency and to ensure the facility is respecting Resident 97's wishes in case of an emergency. During a concurrent interview and record review on 3/13/2025 at 10:30 a.m., reviewed Resident 97's Preferred Intensity of Care Surrogate Decision Maker Form with Registered Nurse (RN) 1. RN 1 stated Resident 97's Preferred Intensity of Care Surrogate Decision Maker Form did not indicate Resident 97's representative was asked if the resident had an AD and/or was offered assistance in the formulation of an AD. RN 1 stated the SSD is responsible in asking the residents and/or their representative if the resident had executed an AD and will be offered assistance to formulate an AD if needed and documented in the medical record. RN 1 stated the SSD should have asked Resident 97's representative for the presence of an AD and/or offer assistance in the formulation if needed. RN 1 stated it was important for the AD information to be in Resident 97's medical record to ensure there is no delay in the provision of necessary care and services in the event of an emergency and to ensure the facility is honoring Resident 97's wishes in case of an emergency. During a review of the facility's recent policy and procedure (P&P) titled, Advanced Directives, last reviewed 9/27/2024, the P&P indicated the following: - The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. - Advance directives are honored in accordance with state law and facility policy. Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. - The resident or representative is given the option to accept or decline assistance, and care will not be contingent on either decision. - Information about whether or not the resident has executed an advance directive is displayed prominently in the medical record in a section of the record that is retrievable by any staff.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on observation, interview, and record review, the facility failed to provide a safe, comfortable, and homelike environment for two (2) of six (6) sampled residents (Residents 79 and 70) reviewed under the environment task by failing to: 1. Ensure Resident 79's floor mat (a cushioned floor pad designed to help prevent injury should a person fall) was free from tears and patched with black tape. 2. Ensure windowsills and baseboards were in good repair and walls were free from red stenciled letters F-L-A-I for one of six sampled residents (Resident 70) reviewed under the Environment task. These deficient practices had the potential to negatively affect the resident's psychosocial wellbeing and make the residents feel uncomfortable in their living space. Findings: a. During a review of Resident 79's Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/29/2024, and readmitted the resident into the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness of the arm, leg, and trunk on the same side of the body) following cerebral infarction (also known as stroke, loss of blood flow to a part of the brain) affecting left non-dominant side. During a review of Resident 79's History and Physical (H&P) dated 9/18/2024, the H&P indicated Resident 79 did not have the capacity to make understand and make decisions. During a review of Resident 79's Order Summary Report, the Order Summary Report indicated a physician's order dated 9/18/2024 for bilateral floor mats to decrease the potential for injury every shift. During a review of Resident 79's Minimum Data Set (MDS, a resident screening tool), dated 2/5/2025, the MDS indicated Resident 79 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required substantial/maximal assistance to total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 79's fall risk assessments dated 11/8/2024 and 2/7/2025, the fall risk assessments indicated the resident was assessed as a high risk for falls. During a review of Resident 79's care plan (CP) titled Falling Star Program, initiated on 9/18/2024 and last revised on 3/11/2025, the CP indicated bilateral floor mats to decrease potential injury as one of the interventions to reduce the risk of falls and/or injury. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/11/2025 at 10 a.m. while inside Resident 79's room, Resident 79's floor mat on the right side had tears in two spots covered with black tape and one tear that was not covered. During a concurrent observation and interview on 3/11/2025 at 10:10 a.m. while inside Resident 79's room with Certified Nursing Assistant (CNA) 10, CNA 10 stated Resident 79's right floor mat had tears in two spots covered with black tape and one tear that was not covered. CNA 10 stated if staff observed any equipment in the room that is in disrepair, the maintenance department should be notified to replace the equipment such as floor mats. CNA 10 stated staff should have notified the maintenance department replace the floor mat. During a concurrent interview and record review on 3/13/2025 at 10 a.m., a photograph of Resident 79's floor mat was observed with Registered Nurse (RN) 1. RN 1 stated Resident 79's floor mat had tears in 2 spots covered with black tape and one tear that was not covered. RN 1 stated the staff should notify the maintenance department to replace the damaged floor mat if they observed the floor mat in disrepair condition inside a resident's room. RN 1 stated the staff should have notified the maintenance department to replace Resident 79's right floor mat as the facility was not providing the resident a homelike environment. RN 1 stated not providing a clean and homelike environment can potentially affect Resident 79's quality of life as the facility is their temporary home while they recover. During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, last reviewed on 12/3/2024, the P&P indicated: - Residents are provided with a safe, clean, comfortable environment. - The facility staff and management minimizes the characteristics of the facility that reflects an institutionalized setting which includes provision of a clean, sanitary, and orderly environment. 44244 b. During a review of Resident 70's Admission Record, the Admission Record indicated the facility admitted the resident on 10/13/2020 and readmitted the resident on 2/14/2025 with diagnoses that included metabolic encephalopathy (a change in the brain function due to injury or disease), lack of coordination, and dementia (a progressive state of decline in mental abilities). During a review of Resident 70's H&P, dated 2/17/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 70's MDS, dated [DATE], the MDS indicated the resident was rarely/never able to understand others and was rarely/never able to make herself understood. The MDS indicated the resident was dependent on assistance from staff for toileting, dressing, personal and oral hygiene, bathing, and mobility. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/11/2025 at 12 p.m., Resident 70 lay in bed awake. Resident 70 did not respond to the surveyor. A large window extending down to the floor was observed on the left of the resident's bed. Under the window, there was a baseboard removed from the wall with a large metal nail extending approximately one inch out of the board outward toward the room and next to Resident 70's wheelchair. The windowsill was broken with jagged, splintering wood. Under the windowsill and next to the broken baseboard, there was dirt and numerous pieces of broken concrete. Certified Nursing Assistant (CNA) 2 entered Resident 70's room, assessed the resident's window and stated the windowsill and baseboard were broken with pieces of concrete and a nail. CNA 2 stated CNA 2 was not assigned to care for Resident 70 and was not aware of the broken baseboard and windowsill and CNA 2 exited Resident 70's room. During a concurrent interview and observation on 3/11/2025 at 12:15 p.m. with CNA 3, CNA 3 entered Resident 70's room and assessed the baseboard and windowsill. CNA 3 stated she was assigned to care for Resident 70 and CNA 3 was not previously aware of the broken baseboard and pieces of concrete. CNA 3 assessed Resident 70's wall and stated there were the red letters F-L-A-I on the wall above the resident's head. CNA 3 stated she did not know why the red letters were on the wall. CNA 3 exited Resident 70's room. During a concurrent interview and observation on 3/12/2025 at 7:56 a.m., with the Assistant Director of Staff Development (ADSD), the ADSD entered Resident 70's room and assessed the baseboard and windowsill. The ADSD stated the window baseboard was broken with two nails sticking out and there was broken concrete pieces behind the baseboard. The ADSD stated the broken baseboard and windowsill did not look safe and should not be like that. The ADSD stated the nails could be a danger to any resident passing by. During a concurrent observation and interview on 3/12/2025 at 8 a.m., with the Maintenance Director (MD), the MD entered Resident 70's room and stated a week prior to 3/12/2025 the MD was replacing the baseboards in Resident 70's room and discovered the concrete needed to be repaired. The MD stated he left the broken board with two nails sticking out, broken windowsill, and pieces of concrete in the resident's room for about one week while waiting to do the repairs. The MD stated the MD did not think the environment was unsafe for the resident. During a concurrent observation and interview on 3/12/2025 at 8:05 a.m., with the Director of Nursing (DON), the DON reviewed the facility policy regarding homelike environment and resident supervision. The DON stated a homelike environment should be safe and homelike with pictures on the wall that the resident would like. The DON observed Resident 70's room and stated the DON was not aware of the broken baseboard with nails, broken windowsill, and pieces of broken concrete at the resident's bedside. The DON stated the resident's room had hazards and was not homelike. The DON stated there was a potential that Resident 70 could get an abrasion from the nail on the board while transferring to the wheelchair. The DON observed the red letters F-L-A-I on the wall above the resident's head and stated the letters had nothing to do with Resident 70 and should not be there. The DON stated the red letters created an environment that was not homelike. The DON stated the letters on the wall and window should have been reported and corrected immediately and they were not. The DON stated it was important to provide a homelike environment for the resident's spirit and to stimulate the resident. The DON stated the facility policy was not followed and could have potentially resulted in affecting Resident 70's psychosocial and emotional wellbeing. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility P&P titled, Homelike Environment, last reviewed 7/25/2024, the P&P indicated residents are provided with a safe, clean, comfortable, and homelike environment. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include clean and sanitary environment and inviting colors and decor.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity including the right to be free from physical restraints (any manual method, physical or mechanical device, equipment, or material that is attached or adjacent to the resident's body, cannot be removed easily by the resident, and restricts the resident's freedom of movement or normal access to his/her body) for two of two sampled residents (Residents 49 and 267) reviewed for restraints by: 1. Failing to complete a restraint assessment, obtain a physician's order, obtain informed consent, and development and implement a care plan prior to application of the bed alarm while in bed for Resident 49. 2. Failing to ensure Resident 267 did not have pillows tucked under the fitted sheet on both sides as observed on 3/13/2025 at 10:11 a.m. These deficient practices had the potential to result in the restriction of residents' freedom of movement, a decline in physical functioning, psychosocial harm, physical harm from entrapment (a state in which a person is trapped by the bed rail in a position that they cannot move from), and death of residents. Findings: a. During a review of Resident 267's Admission Record, the Admission Record indicated the facility originally admitted the resident on 4/9/2017 and readmitted the resident in the facility on 1/18/2025 with diagnoses including dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and history of falling. During a review of Resident 267's History and Physical (H&P), dated 1/27/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 267's Minimum Data Set (MDS, a resident assessment tool), dated 1/24/2025, the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS did not indicate Resident 267 had a restraint. During a review of Resident 267's care plan (CP) on risk for falls or injury initiated on 2/1/2025 and last revised on 3/7/2025, the CP indicated interventions that included to visibly observe resident frequently and provide the resident with a safe and clutter-free environment daily to reduce risk of falls and injury. During a review of Resident 267's fall risk assessment, dated 1/18/2025, the fall risk assessment indicated the resident was a high risk for falls. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 3/13/2025 at 10:11 a.m. inside Resident 267's room, observed resident lying in bed, alert, and answers with mumbling sounds. Observed pillows tucked under Resident 267's fitted sheet on both sides of the bed and the resident appeared sunk in the bed. During a concurrent observation and interview on 3/13/2025 at 10:19 a.m., inside Resident 267's room with Certified Nursing Assistant (CNA) 11, CNA 11 stated Resident 267 had pillows tucked under the fitted sheet on both sides of the bed for safety as the resident had multiple attempts of dangling his legs on the side of the bed. CNA 11 stated Resident 267 already had the pillows tucked under the fitted sheet when he started his shifts. CNA 11 stated he asked a licensed nurse (LN) if it was okay to continue the use of the pillows tucked under the fitted the sheet as he knows it was a form of restraint. CNA 11 stated placing the pillows under the fitted sheets restricts Resident 267's movement such as dangling his legs. During a concurrent interview and review on 3/13/2025 at 10:29 a.m., reviewed Resident 267's fall risk assessment, restraint assessment, physician's order, informed consent, and care plan with Registered Nurse (RN) 1. RN 1 stated Resident 267 was a high risk for fall as he had previous history of falls. RN 1 stated there was no restraint assessment, physician's order, informed consent, and care plan reflecting the use of pillows tucked under Resident 269's fitted sheet. RN 1 stated placing pillows tucked under the fitted sheet on both sides of the bed is not acceptable and is a form of restraint and restricts the resident's movement which may lead to a decline in the resident's functioning. RN 1 stated the pillows tucked under the fitted should not have been placed on Resident 267 as the pillows restrict the resident's freedom of movement and is considered a restraint. During an interview on 3/14/2025 at 2:47 p.m. with the Director of Nursing (DON), the DON stated pillows tucked under the fitted sheet is not an acceptable practice in the facility to prevent the residents from falling. The DON stated if the pillows under the fitted sheet is a family preference, the licensed nurse (LN) was supposed to obtain an order from the physician, obtain informed consent so the family would be aware of the risks and consequences of placing the pillows under the fitted sheet, complete a restraint assessment to ensure the use of restraint is appropriate, and develop and implement a care plan so the staff would be aware of the proper interventions to care for the resident. The DON stated the pillows tucked under the fitted should not have been placed on Resident 267 as the pillows restrict the resident's freedom of movement and is considered a restraint. b. During a review of Resident 49's Admission Record, the Admission Record indicated Resident 49 was originally admitted in the facility on 8/19/2024 and readmitted in the facility on 2/4/2025 with diagnoses including moderate protein-calorie malnutrition (a condition when a person was not getting enough calories and protein leading to a moderate loss of weight and muscle mass), difficulty in walking, and lack of coordination. During a review of Resident 49's H&P, dated 2/122/2025, the H&P indicated Resident 49 had the capacity to understand and make decisions. During a review of Resident 49's MDS, dated [DATE], the MDS indicated the resident had an intact cognition and required supervision or touching assistance with eating; partial/moderate assistance with oral hygiene and personal hygiene; total assistance with lower body dressing; substantial/maximal assistance with all other ADLs. The MDS did not indicate Resident 49 used any type of alarm. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 49's fall risk assessments, dated 1/26/2025 and 2/5/2025, the fall risk assessments indicated Resident 49 was a high risk for falls. During a concurrent observation and interview on 3/11/2025 at 10:04 a.m., inside Resident 49's room with Certified Nursing Assistant (CNA) 10, CNA 10 stated Resident 49 had a bed alarm hanging on the right upper siderail of the bed as he was a high risk for falls as indicated by a yellow start on the wall at the head of the bed. CNA 10 stated the bed alarm was to remind Resident 49 not to get out of bed unassisted. During a concurrent interview and record review on 3/13/2025 at 1:13 p.m., reviewed Resident 49's fall risk assessments dated 1/26/2025 and 2/5/2025, physician's order, restraint assessments, informed consents, and care plan (CP) with Minimum Data Set Nurse (MDSN) 1. MDSN 1 stated Resident 49 was a high risk for falls. MDSN 1 stated Resident 49 did not have a physician's order for the use of bed alarm, hence, no informed consent was obtained from Resident 49 and/or his representative, no restraint assessment, and no care plan developed and implemented reflecting the use of a bed alarm. MDSN 1 stated the bed alarm should not have been used on Resident 49 as there was no physician's order, no informed consent, no restraint assessments, and no care plan was developed and implemented. MDSN 1 stated if all least restrictive interventions to address Resident 49's fall risk have been exhausted, a restraint assessment should have been completed to ensure appropriateness of the restraint use, obtain a physician's order, obtain informed consent from the residents and/or representative to be made aware of the risks and benefits and give them a chance to accept or decline the proposed treatment , and develop and implement a care plan so the other members of the team involved in the resident's care would be aware of the proper intervention needed to keep Resident 49 safe. MDSN 1 stated failing to complete a restraint assessment, obtain a physician's order, obtain informed consent, and develop and implement a care plan for the use of bed alarm, placed Resident 49 at risk for restriction of his movement which may lead to decline in physical function. During an interview on 3/14/2025 at 2:47 p.m. with the DON, the DON stated the licensed nurses (LNs) are responsible to complete a restraint assessment prior to application of restraint for appropriateness of use of a restraint. The DON stated after completion of restraint assessment, the LNs are supposed to obtain an order from the physician who will explain the risks and benefits to the resident and/or representative, the LNs will then obtain an informed, and develop and implement a care plan. The DON stated LNs should have completed the restraint assessment, obtained a physician's order, obtained informed consent, and develop and implement a care plan prior to use of bed alarm on Resident 49 as the facility was restricting Resident 49's freedom of movement which can lead to a decline in function. During a review of the facility's policy and procedure (P&P) titled, Use of Restraints, last reviewed on 9/27/2024, the P&P indicated: - Restraints shall only be used for the safety and well-being of the resident and only after other alternatives have been tried unsuccessfully. - Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Restraints may only be used if/when the resident has a specific medical symptom that cannot be addressed by another less restrictive intervention. - Prior to placing a resident in restraints, there shall be an assessment and review to determine the need for restraints. - Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative. - Residents and/or surrogate/sponsor shall be informed about the potential risks and benefits of all options under consideration, including the use of restraints, not using restrains, and the alternatives to restraint use. - Care plans for residents in restraints will reflect the interventions that address not only the medical symptom(s), but the underlying problems that may be causing the symptom(s). - Care plans shall also include the measures taken to reduce or eliminate the need for restraint use.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 44376 Based on interview and record review, the facility failed to complete and provide a notice of bed-hold policy and return form (reserving a resident's bed while the resident is absent from the facility) when the resident was transferred to general acute care hospital (GACH) 1 for one of three sampled residents (Resident 33) selected for closed record review. This deficient practice had a potential to result in the resident's responsible party being unaware of the bed hold policy and can lead to a transfer of the resident to another skilled nursing facility not of the resident's or responsible party's preference. Findings: During a review of Resident 33's Admission Record, the Admission Record indicated the facility admitted the resident on 3/29/2019, and readmitted the resident on 1/31/2025, with diagnoses including metabolic encephalopathy (a change in how your brain works due to an underlying condition), sepsis (a life-threatening blood infection), and pneumonitis (swelling and irritation, also called inflammation, of lung tissue). During a review of Resident 33's History and Physical (H&P), dated 2/1/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 33's Minimum Data Set (MDS, a resident assessment tool), dated 2/6/2025, the MDS indicated the resident usually had the ability to make self-understood and understand others and had severely impaired cognition (they have trouble with things like memory or paying attention). During a review of Resident 33's Order Summary Report, dated 3/6/2025, the Order Summary Report indicated to transfer Resident 33 to GACH 1 related to (r/t) coffee ground emesis (vomit that looks like coffee grounds), hypotension (low blood pressure), and tachycardia (when the heart beats too fast, at a rate of more than 100 beats per minute, when at rest), seven-day (7-day) bed hold. During a review of Resident 33's Notice of Proposed Transfer/Discharge, dated 3/6/2025, the Notice of Proposed Transfer/Discharge indicated the legal representative was notified and the reason for transfer to GACH 1 was coffee ground emesis, hypotension, and tachycardia. During a concurrent interview and record review on 3/13/2025, at 10:11 a.m., with Registered Nurse (RN) 1, reviewed the discharge medical records of Resident 33. RN 1 stated a written Notification of Bed Hold form was not provided to the resident or representative. RN 1 stated there was an old Notification of Bed Hold done on the chart dated 4/5/2024 but not for the current transfer dated 3/6/2025. RN 1 stated it was important to provide the written Notification of Bed Hold to the resident or representative to ensure they were aware that the resident can come back to the facility within the time frame provided. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/14/2025, at 11:37 a.m., with the Director of Nursing (DON), the DON stated the staff should have provided the 7-day bed hold notification form to Resident 33 or representative. The DON stated the licensed nurses were responsible for making sure the 7-day bed hold notification form was provided to residents being transferred to general acute care hospitals. The DON stated it was important to provide the 7-day bed hold notification form so that the family or resident knows the resident can come back to the facility if they wish. During a review of the facility's recent policy and procedure (P&P) titled Bed-Holds and Returns, last reviewed on 9/27/2024, the P&P indicated residents and/or representatives are informed (in writing) of the facility and state (if applicable) bed-hold policies. All residents/representatives are provided written information regarding the facility bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents are provided written information about these policies at least twice: a. well in advance of any transfer (e.g., in the admission packet); and b. at the time of transfer (or, if the transfer was an emergency, within 24 hours). The written information regarding bed-holds provided to the residents/representatives explains in detail: a. the duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the facility; b. the reserve bed payment policy as indicated by the state plan (for Medicaid residents); c. the facility policies regarding bed-hold periods; d. the facility per diem rate required to hold a bed (for non-Medicaid residents), or to hold a bed beyond the state bed-hold period (for Medicare residents); and e. the return policy.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Deficiency Text Not Available

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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 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38552 Based on interview and record review, the facility failed to timely complete the Minimum Data Set (MDS-a resident assessment tool) Assessment for one of two sampled residents (Resident 16) reviewed under Resident Assessments facility task by, failing to complete Resident 126's MDS Quarterly Assessment timely. This deficient practice had the potential to negatively affect the provision of necessary care and services needed by the resident. Findings: During a review of Resident 16's Admission Record, the Admission Record indicated the facility admitted the resident on 9/20/2024 with diagnoses including type II diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and hypertension (HTN-high blood pressure). During a review of Resident 16's History and Physical (H&P), dated 10/1/2024, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 16's MDS, dated [DATE], the MDS indicated in section Z0500B, dated 1/13/2025, the registered nurse (RN) assessment coordinator signed the assessment as complete. During a concurrent interview and record review on 3/12/2025 at 1:56 p.m. with MDS Nurse (MDSN) 1, the Final Validation Report (facility's documentation of successful MDS file submission), dated 1/15/2025 was reviewed. The Final Validation Report indicated Resident 16's MDS assessment was completed late. MDSN 1 stated the Final Validation Report indicated the assessment completion date was more than 14 days after the assessment reference date of 12/27/2024. MDSN 1 stated this was Resident 16's MDS Quarterly Assessment which should have been completed on 1/10/2025 and if after this date is considered late. During an interview on 3/14/2025 at 2:49 p.m. with the Director of Nursing (DON), the DON stated the MDS Assessments should be completed timely and should reflect the patient's health status at that time. The DON stated when the MDS Assessments are not completed timely there could be a delay in reporting of the resident's health status and reporting of the quality measures. During a review of the facility's policy and procedure (P&P) titled, MDS Completion and Submission Timeframes, last reviewed 9/27/2024, the P&P indicated Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual. (continued on next page)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	During a review of the Centers for Medicare &Medicaid Services (CMS, a federal agency that administers major healthcare programs) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2024, the RAI manual indicated the MDS Completion Date (Item Z0500B) no later than assessment reference date (ARD) + 14 calendar days.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38552 Based on interview and record review, the facility failed to ensure residents received an accurate assessment, reflective of the resident's status at the time of the assessment by failing to: 1. Accurately code Resident 2's MDS assessment to reflect the resident's admitted to the facility for one of two sampled residents (Resident 2) reviewed under Resident Assessment facility task. 2. Accurately code Resident 49's MDS assessment to reflect the resident was discharged with return not anticipated on 1/8/2025. This deficient practice had the potential to affect Resident 2 and Resident 49's plan of care and delivery of necessary care and services. Findings: 1. During a review of Resident 2's Admission Record, the Admission Record indicated the resident was admitted on [DATE] with diagnoses including type II diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), schizophrenia (a mental illness that is characterized by disturbances in thought), and hypertension (HTN-high blood pressure). During a review of Resident 2's physician order, dated 10/3/2024, the physician order indicated to admit the resident under Medicare A (health insurance program that helps pay a portion of the costs for covered services) for the following services: rehabilitation services and skilled nursing services. During a review of Resident 2's History and Physical (H&P), dated 10/8/2024, the H&P indicated the resident had the capacity to understand and make decisions. During a concurrent interview and record review on 3/12/2025 at 2:06 p.m. with MDS Nurse (MDSN) 1, Resident 2's MDS Entry assessment dated [DATE] was reviewed. The MDS Entry Assessment Section A1900 admitted was also noted as 10/4/2024. MDSN 1 stated Resident 2 was admitted on [DATE] and she filled this out incorrectly. MDSN 1 stated she will do a modified version to correct the resident's entry date. During an interview on 2/28/2025 at 9:01 a.m. with the Director of Nursing (DON), the DON stated the MDS assessments should be completed accurately. This is to ensure accuracy of the entry and ensure it is the correct resident and to avoid duplication. The DON stated this is an inaccurate health status of the resident and would affect the billing During a review of the facility's policy and procedure (P&P) titled Certifying Accuracy of the Resident Assessment, last reviewed on 9/27/2024, the P&P indicated the any person completing a portion of the MDS must sign and certify the accuracy of that portion of the assessment. 43988 (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	2. During a review of Resident 49's Admission Record, the Admission Record indicated Resident 49 was originally admitted into the facility on [DATE] and was readmitted on [DATE] with diagnoses including moderate protein-calorie malnutrition (a condition when a person was not getting enough calories and protein leading to a moderate loss of weight and muscle mass), difficulty in walking, and lack of coordination. During a review of Resident 49's progress note, dated 1/8/2025 at 5:36 p.m., the progress note indicated Resident 49 left the facility against the physician's medical advice. During a review of Resident 49's H&P, dated 2/12/2025, the H&P indicated Resident 49 had the capacity to understand and make decisions. During a concurrent interview and record review on 3/12/2025 at 2:22 p.m., Resident 49's MDS, Section A0310 Type of Assessment, Section A2000 discharge date , and Section A2105 dated 1/8/2025 was reviewed with MDSN 1. MDSN 1 stated the MDS Assessment Section A0310 indicated the type of assessment was a 5-day scheduled assessment for Medicare Part A stay and the assessment was not an entry/discharge type of assessment. MDSN 1 stated Section A2000 did not indicate Resident 49's discharge date from the facility, and Section A2105 did not indicate location of discharge status. MDSN 1 stated Resident 49's MDS assessment Sections A2000 and A2105 should have indicated Resident 49's discharge date from the facility and discharge return not anticipated. MDSN 1 stated Resident 49's MDS assessment was not coded accurately, and it can potentially cause confusion with regards to Resident 49's status in the facility which could lead to a delay in the care and services the resident needed. During an interview on 3/14/2025 at 2:47 p.m. with the DON, the DON the stated the MDS assessment are signed by the MDSN 1 as complete and accurate prior to submission to reflect the resident's current status for billing purposes and quality to prevent delay in the delivery of care and services the residents need. The DON stated Resident 49's MDS assessment should have indicated the resident was discharged with return as not anticipated to prevent confusion with Resident 49's current status if still in the facility or not which may lead to delay in providing the care and services Resident 49 needed. During a review of the facility's P&P titled, Certifying Accuracy of the Resident Assessment, dated 9/27/2024, the P&P indicated: - Any person completing a portion of the MDS must sign and certify the accuracy of that portion of the assessment. - The information captured on the assessment reflects the status of the resident during the observation period for that assessment. During a review of the facility's P&P titled, Resident Assessment, last reviewed on 9/27/2024, the P&P indicated: 1. The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews according to the following requirements: a. OBRA required assessment - conducted for all residents in the facility: (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	(7) Discharge Assessment (return anticipated and return not anticipated). 8. All persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information.

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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** 43455 Based on interview and record review, the facility failed to ensure residents received person-centered care by failing to implement the Care Plan (a document outlining a detailed approach to care customized to an individual resident's need) for two (2) of three (3) sampled residents (Resident 42 and 79) reviewed for unnecessary medications (any drug in excess) by failing to: 1a. Monitor the side effects (also known as adverse consequences - unwanted, uncomfortable, or dangerous effects that a drug may have) of clopidogrel (a medication used for paroxysmal atrial fibrillation [irregular and fast heartbeat] that thins the blood) and Eliquis (a medication used for atrial fibrillation that thins the blood) for Resident 42. As a result, Resident 42 did not have monitoring for sign and symptoms of bleeding for the use of clopidogrel and Eliquis between 3/1/2025 and 3/13/2025. 1b. Monitor the side effects of gabapentin (a medication used for epilepsy [seizure - bursts of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle movements, behaviors, sensations or states of awareness]) for Resident 42. As a result, Resident 42 did not have monitoring for signs and symptoms of drug toxicity (accumulation of an excessive amount of any medication in the bloodstream) with the use of gabapentin between 3/1/2025 and 3/13/2025. 2. Monitor Resident 79's lipid panel (blood test that measures levels of fats [lipids], including cholesterol and triglycerides, to assess risk of heart disease) with the use of atorvastatin (a medication used for hyperlipidemia [having high lipid levels in the blood]) since 9/17/2024. These deficient practices had the potential to cause Resident 42 and 79 to receive suboptimal (less than the highest standard or quality) care leading to the use of unnecessary medications causing potential side effects and negatively impacting their physical, mental, and psychosocial well-being. Cross-reference F756 and F757. Findings: A. During a review of Resident 42's Admission Record (a document containing demographic and diagnostic information), dated 3/13/2025, the Admission Record indicated Resident 42 was originally admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis including epilepsy and paroxysmal atrial fibrillation. During a review of Resident 42's Order Summary Report, dated 3/13/2025, the Order Summary Report indicated Resident 42 was prescribed the following: 1. Eliquis 5 mg to give one (1) tablet by mouth once a day for atrial fibrillation, starting 4/25/2024 2. Clopidogrel 75 mg to give one (1) tablet by mouth once a day for paroxysmal atrial fibrillation, starting 8/2/2024 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Gabapentin 600 mg to give one (1) tablet by mouth three (3) times a day for epilepsy, starting 4/29/2024 During a review of Resident 42's Care Plan, initiated 4/20/2024, the Care Plan indicated Resident 42 was: 1. At risk for bleeding and bruising due to anticoagulant (blood thinner) therapy Eliquis. Risk factors: Abnormal bleeding. Easy skin bruising or discolorations. Goal: no unrecognized sign and symptoms of bleeding .daily. Assess for signs and symptoms of bleeding. Assess for other possible causes of bruising. 2. At risk for injury, ineffective breathing pattern, confusion, and disorientation because of seizure activity. [Resident 42 is] at risk for potential drug toxicity related to [the resident's] use of gabapentin. [The resident's] risk of complications and injury will be minimized through appropriate interventions. Observe for signs and symptoms of drug toxicity such as nausea, vomiting, dizziness, severe drowsiness, blurred visions, double vision, altered level of consciousness, chest pain and shortness of breath and notify medical doctor. Staff will assess for febrile reactions (these may precipitate seizures.) Staff will assess for potential side effects of medication and will notify [the] physician as needed. During a review of Resident 42's Medication Administration Record (MAR - a record of medication administrations and medication related monitoring), dated March 2025, the MAR indicated Resident 42 was prescribed the following: 1. Eliquis 5 mg one (1) tablet by mouth once a day for atrial fibrillation to be given at 9 a.m. 2. clopidogrel 75 mg one (1) tablet by mouth twice a day for paroxysmal atrial fibrillation to be given at 9 a.m. and 5 p.m. 3. gabapentin 600 mg one (1) tablet by mouth three (3) times a day for epilepsy to be given at 9 a.m., 1 p.m. and 5 p.m. The MAR did not contain documentation for monitoring for signs and symptoms of bleeding and bruising with the use of clopidogrel and Eliquis, and did not contain monitoring for signs and symptoms of drug toxicity with the use of gabapentin. B. During a review of Resident 79's Admission Record dated 3/14/2025, the Admission Record indicated Resident 79 was originally admitted to the facility on [DATE]and readmitted on [DATE] with a diagnosis including hyperlipidemia. During a review of Resident 79's Order Summary Report, dated 3/12/2025, the report indicated Resident 79 was prescribed atorvastatin 20 mg give one (1) tablet by mouth at bedtime for hyperlipidemia, starting 9/17/2024. During a review of Resident 79's MAR, dated March 2025, the MAR indicated Resident 79 was prescribed atorvastatin 20 mg one (1) tablet by mouth at bedtime for hyperlipidemia, to be given at 9 p.m. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 79's Care Plan, initiated 9/18/2024, the Care Plan indicated Resident 79: Is at risk for cardiac distress related to . hyperlipidemia (HLD). Goal - will have no unrecognized signs and symptoms of cardiac distress daily until the next assessment. Monitor effect of medication. Inform medical doctor if ineffective. Laboratory work as ordered. Inform Medical doctor of result promptly. During a review of Resident 79's clinical chart, on 3/12/2025, at 1:48 p.m., the clinical chart did not contain an order to obtain a lipid panel since admission, and the record did not contain any lipid laboratory results prior to admission. During a concurrent record review and interview, on 3/13/2025, at 10:41 a.m., with the Director of Nursing (DON), Resident 42's Care Plan, dated 4/20/2024, and MAR, dated March 2025, were reviewed. The DON stated Resident 42's Care Plan indicated Resident 42 was at risk of bleeding and bruising and to assess for signs and symptoms of bleeding and bruising related to blood thinner use, and was at risk for potential drug toxicity and to observe for signs and symptoms of drug toxicity related to gabapentin use. The DON stated monitoring for bleeding and bruising and signs and symptoms of drug toxicity would be documented on the MAR. The DON stated she was unable to locate documentation for monitoring for bleeding and bruising related to use of clopidogrel and Eliquis and signs and symptoms of drug toxicity related to use of gabapentin on Resident 42's MAR. The DON stated monitoring for bleeding and bruising with clopidogrel and Eliquis use was important to ensure Resident 42 does not have bleeding that was unnoticed, which may harm the resident leading to hospitalization and death. The DON stated monitoring for drug toxicity with gabapentin use was important to minimize the side effects of gabapentin and prevent harm such as chest pain and shortness of breath to Resident 42. The DON stated the facility failed to implement the Care Plan to accurately reflect the needs of Resident 42 and ensure to maintain the highest level of functionality and quality of life, with adequate (acceptable) side effect monitoring with the use of clopidogrel, Eliquis and gabapentin. The DON stated that monitoring signs and symptoms of side effects related to Eliquis, clopidogrel and gabapentin will be immediately implemented for Resident 42. The DON stated monitoring for bleeding with blood thinner use was considered standard of practice. During a concurrent interview and record review with the DON, on 3/13/2025, at 10:41 a.m., Resident 79's clinical chart, Care Plan, dated 9/18/2024, and MAR, dated March 2025, were reviewed. The DON stated Resident 79's Care Plan indicated Resident 79 was at risk for cardiac distress related to hyperlipidemia and to monitor effect of medication and laboratory work. The DON stated the DON was unable to locate any laboratory results for lipid panel prior to and since admission to the facility. The DON stated it was important to check for lipid levels for residents using atorvastatin to know if the medications was effective, and not causing more harm than benefit. The DON stated the facility failed to implement the Care Plan to accurately reflect the needs of Resident 79 and ensure to maintain the highest level of functionality and quality of life, with adequate monitoring for lipid levels with the use of atorvastatin. The DON stated lipid panel monitoring was considered a standard of practice. (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 3/18/2025, at 1:48 p.m., with the Consultant Pharmacist (CP), the CP stated Resident 42 should be monitored for the side effects of bleeding and bruising with the use of clopidogrel and Eliquis. The CP stated the concern with lack of monitoring for the side effects of clopidogrel and Eliquis may result in harming Resident 42 by causing bleeding that may go unnoticed. The CP stated Resident 79 should be monitored for lipid levels at least once at admission and possibly once a year to ensure the atorvastatin was effective in lowering the lipid levels and if any changes to the dose or the medication was necessary. The CP stated the CP reviewed and completed Resident 42's and 79's drug regimen review for December 2025, January 2025, and February 2025 and failed to identify lack of monitoring for bleeding and bruising for clopidogrel and Eliquis, and lack of monitoring for side effects of gabapentin for Resident 42 and failed to identify lack of lipid panel monitoring for Resident 79 in the monthly written reports to the facility. The CP stated monitoring was considered standard of practice and without adequate monitoring these medications have the potential to be used unnecessarily causing more harm than benefit to Resident 42 and 79. During a review of the facility's Policy & Procedures (P&P) titled, Care Plan Comprehensive, last reviewed 9/27/2024, the P&P indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's medical, physical, mental and psychosocial needs is developed and implemented for each resident. 7. The comprehensive person-centered care plan: b. Describes the services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being. e. reflects currently recognized standards of practice for problem areas and conditions. During a review of facility P&P titled, Anticoagulation - Clinical Protocol, last reviewed 9/27/2024, the P&P indicated: 1. As part of the initial assessment, the physician and staff will identify individuals who are currently anticoagulated: for example, those with recent history of .atrial fibrillation. a. Assess for any signs or symptoms related to adverse drug reactions due to the medication alone or in combination with other medications. 5. The staff and physician will monitor for possible complications in individuals who are being anticoagulated . During a review of facility P&P titled, Medication Regimen Review, last reviewed 9/27/2024, the P&P indicated The CP performs a comprehensive medication regimen review at least monthly. The Medication Regimen Review includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy. During a review of the facility's P&P, titled Adverse consequences and Medication Errors, last reviewed 9/27/2024, the P&P indicated: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Residents receiving any medication that has a potential for an adverse consequence will be monitored to ensure that any such consequences are promptly identified and reported. 2. An 'adverse consequence' is defined as an unpleasant symptom or event that is due to or associated with a medication, such as an impairment or decline in an individual's mental or physical condition or functional or psychosocial status. An adverse consequence may include: a. Adverse drug/medication reaction b. Side effect 4. The staff and practitioner shall strive to minimize adverse consequences by: a. Following relevant clinical guidelines and manufacturer's specifications for use, dose, administration, duration, and monitoring of the medication.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 43988 2. During a review of Resident 17's Admission Record, the Admission Record indicated the facility originally admitted the resident on 11/2/2021 and readmitted in the facility on 9/22/2024 with diagnoses including type 2 diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing), long term use of insulin, and dementia (a progressive state of decline in mental abilities). During a review of Resident 17's H&P, dated 9/25/2024, the H&P indicated Resident 17 did not have the capacity to understand and make decisions. During a review of Resident 17's MDS, dated [DATE], the MDS indicated Resident 17 had moderately impaired cognition and required substantial/maximal assistance to total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS further indicated Resident 17 received insulin. During a review of Resident 17's Order Summary Report, the Order Summary Report indicated the following physician's orders dated 9/22/2024: - Humalog injection solution (insulin lispro - a short acting insulin) 100 unit/ml. Inject subcutaneously before meals and at bedtime for DM 2, give insulin five (5) to 10 minutes before meals, rotate injection site. Inject as per sliding scale (increasing administration of the pre?meal insulin dose based on the blood sugar level before the meal): if 60 - 150 = 0; 151 - 200 = 1; 201 - 250 = 2; 251 - 300 = 3; 301 - 350 = 4; 351 - 400 = 5; 401+ = 6. Call physician (MD) if blood sugar is greater than 400 milligram per deciliter (mg/dl - a unit of measurement) or less than 70 mg/dl. During a concurrent interview and record review, on 3/13/2025, at 10:38 a.m., with RN 1, Resident 17's physician's orders, Medication Administration Record (MAR - a daily documentation records used by a licensed nurse to document medications and treatments given to a resident) Location of Administration Report dated 1/2025 to 3/2025 was reviewed. RN 1 stated Resident 17 had a physician's order for insulin lispro and were administered as follows: - Humalog injection solution 100 unit/ml (Insulin Lispro): 1/03/25 9:26 p.m. subcutaneously abdomen - LUQ 1/04/25 4:14 p.m. subcutaneously abdomen - LUQ 1/24/25 11:18 a.m. subcutaneously abdomen - LUQ 1/24/25 3:42 p.m. subcutaneously abdomen - LUQ 1/24/25 9:00 p.m. subcutaneously abdomen - LUQ (continued on next page)

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Sherman Oaks Health & Rehab	14401 Huston St. Sherman Oaks, CA 91423

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/27/25 9:53 p.m. subcutaneously abdomen - right lower quadrant (RLQ) 1/28/25 11:53 a.m. subcutaneously abdomen - RLQ RN 1 stated insulin administration sites should be rotated per standards of practice, manufacturer's guidelines, and according to physician's orders. RN 1 stated Resident 17's MAR indicated the insulin administration sites were not rotated and there was a physician's order to rotate injection sites. RN 1 stated Resident 17's insulin administration sites should have been rotated per standards of practice to prevent pain, redness, irritation, bruising, and pits on the resident's skin. During an interview, on 3/14/2025, at 2:45 p.m., with the DON, the DON stated the Licensed Nurses (LN) should have rotated Resident 17's insulin injection site to prevent bleeding, thinning of the skin, injury to the site, and development of lipodystrophy. The DON stated the LN should have followed the manufacturer's guideline and physician's order to rotate injection sites. During a review of the facility provided manufacturer's guideline for insulin lispro, undated, the manufacturer's guideline indicated: - Change (rotate) your injection sites within the area you choose for each dose to reduce your risk of getting lipodystrophy (pits in skin or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. - Do not inject where the skin has pits, is thickened, or has lumps. - Do not inject where the skin is tender, bruised, scaly or hard, or into scars or damaged skin. - Choose your injection site: insulin lispro is injected under the skin of your stomach area, buttocks, upper legs or upper arms. During a review of the facility's recent P&P titled, Insulin Administration, last reviewed on 9/27/2024, the P&P indicated a purpose to provide guideline for the safe administration of insulin to residents with diabetes. The P&P further indicated: - Select an injection site: a. Insulin may be injected into the subcutaneous tissue of the upper arm and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). 3. During a review of Resident 48's Admission Record, the Admission Record indicated the facility originally admitted the resident on 4/27/2024 and readmitted in the facility on 1/29/2025 with diagnoses including DM 2, congestive heart failure (CHF - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and generalized weakness. During a review of Resident 48's H&P, dated 1/30/2025, the H&P indicated Resident 48 had the capacity to understand and make decisions. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 48's MDS, dated [DATE], the MDS indicated Resident 48 had an intact cognition and required supervision or touching assistance with eating and oral hygiene, partial/moderate assistance with upper body dressing, and substantial/maximal assistance from staff with all other ADLs. The MDS further indicated Resident 48 received insulin. During a review of Resident 48's Order Summary Report, the Order Summary Report indicated the following physician's orders dated 1/29/2025: - Insulin glargine (a long-acting insulin) subcutaneous solution pen-injector 100 unit/ml inject eight (8) unit subcutaneously in the morning for DM 2. Administer before breakfast (rotate injection sites) hold for fingerstick blood sugar (FSBS) less than (<) 100. - Insulin Lispro (1 unit Dial) subcutaneous solution pen-injector 100 unit/ml Inject subcutaneously before meals and at bedtime for DM 2 for FSBS more than 400 give 12 units and call MD. Notify MD if blood sugar is above 400 or below 60; give insulin 5 - 10minutes before mealtime, may give orange juice eight (8) ounces (oz) or glucose gel by mouth if blood sugar below 60. Inject as per sliding scale: if 60 - 150 = 0 unit; 151 - 200 = 2 units; 201 - 250 = 4 Units; 251 - 300 = 6 Units; 301 - 350 = 8 Units; 351 - 400 = 10 Units. During a concurrent interview and record review, on 3/13/2025, at 10:45 a.m., with RN 1, Resident 48's physician's orders, MAR, Location of Administration Report, dated 1/2025 to 3/2025, was reviewed. RN 1 stated Resident 48 had a physician's order for insulin lispro and insulin glargine and were administered as follows: - Insulin glargine subcutaneous solution pen-injector 100 unit/ml: 2/03/25 6:15 a.m. subcutaneously abdomen -LLQ 2/04/25 7:18 a.m. subcutaneously abdomen - LLQ 2/13/25 7:11a.m. subcutaneously abdomen - LLQ 2/14/25 7:19 a.m. subcutaneously abdomen - LLQ 2/19/25 7:05 a.m. subcutaneously abdomen - LUQ 2/20/25 6:52 a.m. subcutaneously abdomen - LUQ - Insulin lispro subcutaneous solution pen-injector 100 unit/ml: 2/02/25 9:17 p.m. subcutaneously abdomen - RLQ 2/03/25 9:38 p.m. subcutaneously abdomen - RLQ 2/10/25 9:56 p.m. subcutaneously abdomen - right upper quadrant (RUQ) 2/12/25 8:57 p.m. subcutaneously abdomen - RUQ (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN 1 stated insulin administration sites should be rotated per standards of practice, manufacturer's guidelines, and according to physician's orders. RN 1 stated Resident 48's MAR indicated the insulin administration sites were not rotated and there was a physician's order to rotate injection sites. RN 1 stated Resident 48's insulin administration sites should have been rotated per standards of practice to prevent pain, redness, irritation, bruising, and pits on the resident's skin. During an interview, on 3/14/2025, at 2:45 p.m., with the DON, the DON stated the LN should have rotated Resident 48's insulin injection site to prevent bleeding, thinning of the skin, and injury to the site. The DON further stated to prevent development of lipodystrophy. The DON the LN should have followed the manufacturer's guideline and physician's order to rotate injection sites. During a review of the facility provided manufacturer's guideline for insulin lispro, undated, the manufacturer's guideline indicated: - Change (rotate) your injection sites within the area you choose for each dose to reduce your risk of getting lipodystrophy (pits in skin or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. - Do not inject where the skin has pits, is thickened, or has lumps. - Do not inject where the skin is tender, bruised, scaly or hard, or into scars or damaged skin. - Choose your injection site: insulin lispro is injected under the skin of your stomach area, buttocks, upper legs or upper arms. During a review of the facility's recent P&P titled, Insulin Administration, last reviewed on 9/27/2024, the P&P indicated a purpose to provide guideline for the safe administration of insulin to residents with diabetes. The P&P further indicated: - Select an injection site: a. Insulin may be injected into the subcutaneous tissue of the upper arm and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). 44376 Based on interview and record review, the facility's licensed nursing staff failed to provide care in accordance with professional standards to three (3) of four sampled residents (Residents 107, 17, and 48) reviewed for insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (beneath the skin) insulin administration sites. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This deficient practice had the potential for adverse effect (unwanted, unintended result) of same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Cross reference F760. Findings: 1. During a review of Resident 107's Admission Record, the Admission Record indicated the facility admitted the resident on 2/17/2025, with diagnoses including type two (2) diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), lack of coordination, and chronic kidney disease stage 3 (when the kidneys have mild to moderate damage and are less able to filter waste and fluid out of the blood). During a review of Resident 107's History and Physical (H&P), dated 2/19/2025, the H&P indicated the resident was alert and oriented to person, place, and time. The H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 107's Minimum Data Set (MDS - a resident assessment tool), dated 2/23/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a participant who has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). The MDS indicated the resident was on a high-risk drug class hypoglycemic medication (a group of drugs used to help reduce the amount of sugar present in the blood). During a review of Resident 107's Order Summary Report, the Order Summary Report indicated an order for: On 2/17/2025, Insulin Aspart Solution 100 unit per milliliters (unit/ml, a milliliter is a unit of fluid volume equal to one-thousandth of a liter). Inject 6 unit subcutaneously before meals for diabetes mellitus type 2 (DM2). Administer before breakfast. On 2/20/2025, Insulin Glargine Solution 100 unit/ml. Inject 15 unit subcutaneously every 12 hours for DM2. During a review of Resident 107's Location of Administration Report of Insulin for 2/2025 to 3/2025, the Location of Administration Report indicated Insulin Glargine Solution 100 unit/ml was administered subcutaneously on: 2/22/2025 at 9:40 a.m. at the Abdomen - Left Lower Quadrant (LLQ) 2/22/2025 at 9 p.m. at the Abdomen - LLQ 2/22/2025 at 10:41 a.m. at the Abdomen - Left Upper Quadrant (LUQ) 2/22/2025 at 4:30 p.m. at the Abdomen - LUQ (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/24/2025 at 4:19 p.m. at the Abdomen - LLQ 2/25/2025 at 7:16 a.m. at the Abdomen - LLQ 2/27/2025 at 5:27 p.m. at the Abdomen - LUQ 2/28/2025 at 7:09 a.m. at the Abdomen - LUQ During a concurrent interview and record review, on 3/13/2025, at 10:33 a.m., with Registered Nurse (RN) 1, Resident 107's Order Summary Report and Location of Administration Report of Insulin, dated 2/2025 to 3/2025, was reviewed. RN 1 stated there were multiple times where the insulin administration sites were not rotated from 2/2025 to 3/2025 for Resident 107. RN 1 stated the licensed nurses should rotate insulin administration sites to prevent phlebitis (an inflammation that causes a blood clot to form in a vein, usually in the leg), hematoma (a collection of blood outside of a blood vessel caused by a broken blood vessel), pain, and lipodystrophy on residents. During an interview, on 3/14/2025, at 11:37 a.m., with the Director of Nursing (DON), inside the facility's conference room, the DON stated the licensed nurses should have rotated the insulin administration sites of Resident 107 to prevent bleeding, thinning of the skin, injury to the site, and lipodystrophy on the resident. During a review of the facility's recent policy and procedure (P&P) titled, Insulin Administration, last reviewed on 9/27/2024, the P&P indicated to provide guidelines for the safe administration of insulin to residents with diabetes. Select an injection site. a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility-provided Highlights of Prescribing Information on the use of Lantus (insulin glargine injection) for subcutaneous injection, with initial U.S. approval in 2000, the Highlights of Prescribing Information indicated to rotate injections sites to reduce the risk of lipodystrophy.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38552 Based on interview and record review, the facility failed to follow the Do Not Resuscitate (DNR- a written document signed by the patient or their legal representative and the patient's physician, and it is placed in the patient's medical records indicating the resident's wishes of withholding resuscitation efforts) physician order for one of one sampled resident (Resident 115) when cardiopulmonary resuscitation (CPR-emergency procedure used to restart a person's heartbeat and breathing after one or both have stopped) was administered to Resident 115. This deficient practice violated the resident's preferred treatment wishes. Cross-reference: F550 Findings: During a review of Resident 115's Admission Record, the Admission Record indicated the facility originally admitted the resident on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (a condition where the brain does not work normally because of problems with the body's metabolism [how the body manages food, energy, or chemicals]), sepsis (a life-threatening blood infection), and dementia (a progressive state of decline in mental abilities). During a review of Resident 115's Preferred Intensity of Care (PIC) Authorization/Decisions, dated [DATE], the PIC Authorization/Decisions indicated the resident's representative authorized no CPR and that the resident was not capable of making preferred intensity decisions and requested that the withholding of the above-described medical care was consistent with the views of the resident. During a review of Resident 115's History and Physical (H&P- a comprehensive assessment that involves a thorough medical history and a physical examination, forming the foundation for resident care and guiding diagnostic and treatment decisions), dated [DATE], the H&P indicated the resident did not have the capacity to understand and make decisions. The H&P indicated the resident did not want CPR. During a review of Resident 115's Minimum Data Set (MDS-a resident assessment tool), dated [DATE], the MDS indicated the resident had clear speech, moderately impaired vision, and was rarely/never makes self understood and rarely/never had the ability to understand others. The MDS indicated the resident had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 115's Change in Condition (COC-a major decline in the resident's status) Assessment Form, dated [DATE], indicated the COC Assessment Form on [DATE] at 7:20 p.m., Resident 115 was found unresponsive and no vital signs (measurements of the body's most basic functions such as body temperature, heart [pulse] rate, respiration rate [rate of breathing], and blood pressure [pressure of circulating blood against the walls of blood vessels]) appreciated (no signs of life, such as a heartbeat, breathing, or movement, were detected or observed). The COC Assessment Form indicated chest compression was started, and code blue (a standardized alert system used to indicate a medical emergency, typically a person's heartbeat and breathing after one or both have stopped, requiring immediate resuscitation efforts) was announced. The COC Assessment Form indicated 911 (emergency telephone number) was called and paramedics arrived at the facility, relieved the licensed nurses, and continued to provide CPR to Resident 115 for another 25 minutes. The COC Assessment Form indicated at 7:50 p.m. CPR was stopped, and Resident 115 was pronounced expired. The COC Assessment Form indicated at 8 p. m. the resident's representative was notified. During a concurrent interview and record review on [DATE] at 9:46 a.m. with MDS Nurse (MDSN) 1, Resident 115's PIC Authorization/Decisions, dated [DATE] and physician orders were reviewed. MDSN 1 stated there was code/CPR status entered on the physician order in the resident's electronic health record. MDSN 1 stated the resident's PIC Authorization/Decisions form should have been reviewed by the social services with the resident's representative if they wanted any changes. MDSN 1 stated this should have been filed in the resident's current closed chart when he was readmitted on [DATE]. MDSN 1 stated it was filed in the resident's old chart with discharge date [DATE]. MDSN 1 stated this allows facility staff to know what the resident's preferred treatment is. MDSN 1 stated if this was not filed in the resident's current chart the resident could be considered full code status. During a concurrent interview and record review on [DATE] at 2:28 p.m. with the Social Services Director (SSD), Resident 115's PIC Authorization/Decisions, dated [DATE], Social Service Note, dated [DATE], and COC Assessment Form, dated [DATE] were reviewed. The SSD stated she documented that she informed the resident's representative that the resident will remain full code status until a Physician's Orders Life Sustaining Treatment (POLST- portable medical orders that communicate patient wishes for end-of-life intervention to health care facilities and providers, including emergency medical services) or an Advance Directive (AD-a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a physician). The SSD stated both POLST and AD are optional, and residents are not obligated to have unless they prefer to. The SSD stated when Resident 115 was readmitted to the facility on [DATE] and on [DATE] she did not see the PIC Authorization/Decisions form on the resident's chart, so she reached out to the resident's representative. The SSD stated she should have asked medical records to check on the resident's previous PIC Authorization/Decisions form. The SSD stated their facility's DNR policy and procedure (P&P) is to follow the DNR order unless the resident or resident's representative request to end the DNR order. The SSD stated when the resident's signed PIC Authorization/Decisions form was not filed on the resident's chart the resident will not receive their preferred care and their resident's rights of preferred treatment would not be followed and respected. The SSD stated POLST and AD acknowledgement form are done upon admission or the following day and Monday if the resident was admitted over the weekend. The SSD stated Resident 115 had a COC on [DATE] where the resident was found unresponsive with no vital signs were appreciated and CPR was administered. The SSD stated she missed it and the resident received CPR who had a DNR order. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 3:07 p.m. with the Director of Nursing (DON), the DON stated the resident's/resident's representatives are not required to complete the POLST or an advance directive are optional. The DON stated what the residents or resident's representative fills out is the advance directive acknowledgement form (document provided by the facility that indicates whether a resident has an advance directive, would like information regarding creation of an advance directive, or refusal to create an advance directive) which would indicate the resident's preferred intensity of care. The DON stated it is very important to follow upon the resident's admission and ask the medical record staff to bring up the resident's preferred intensity of treatment in the new chart because it reflects the resident's wishes. The DON stated if the resident/resident's representative does not have one they can offer and make a new preferred intensity of care. The DON stated this should have been done as soon as possible if the resident was admitted on the weekend either the next day or go by the code status order from the hospital record. During a review of the facility's P&P titled, Resident Rights, last reviewed [DATE], the P&P indicated employees shall treat all residents with kindness, respect, and dignity. The P&P indicated These rights include the resident's right to: a. Dignified existence. b. Be treated with respect, kindness, and dignity; During a review of the facility's P&P titled, Do Not Resuscitate Order, last reviewed [DATE], the P&P indicated the facility will not use cardiopulmonary resuscitation and related emergency measures to maintain life functions on a resident when there is a Do Not Resuscitate Order in effect. The P&P indicated Do Not Resuscitate orders must be signed by the resident's attending physician on the physician's order sheet maintained in the resident's medical record. The P&P indicated DNR orders will remain in effect until the resident (or legal surrogate) provides the facility with a signed and dated request to end the DNR order. During a review of the facility's P&P titled, POLST, last reviewed [DATE], the P&P indicated Just because POLST is offered does not mean the resident or legal representative must complete one. No one is required to complete a POLST form as it is 100% voluntary.

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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 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. 44376 Based on interview and record review, the facility failed to ensure residents who experienced a significant change of status is comprehensively assessed for one of one sampled resident (Resident 3) reviewed under change of condition by failing to perform a change of condition assessment on 8/25/2024, when the resident was discharged to General Acute Care Hospital (GACH) 2 for abnormal laboratory and elevated white blood cells (WBC, a part of the immune system that protects your body from infection) and blood urea nitrogen (BUN, measures the amount of a waste product called urea nitrogen in your blood, which is a byproduct of protein breakdown, and helps doctors assess kidney function). This deficient practice had the potential to negatively affect the provision of necessary care and services. Findings: During a review of Resident 3's Admission Record, the Admission Record indicated the facility admitted the resident on 3/24/2007, and readmitted the resident on 9/4/2024, with diagnoses including metabolic encephalopathy (a change in how your brain works due to an underlying condition), acute and chronic respiratory failure (is a sudden, life-threatening inability of the lungs to exchange enough oxygen and carbon dioxide, requiring immediate medical attention. Chronic respiratory failure is a long-term, gradual problem where the lungs struggle to do the same, often needing ongoing treatment), and presence of vascular implants (the integration of a fabricated vasculature into the host circulation to support tissue health and function) and grafts (tissue transplanted or implanted in a part of the body to repair a defect). During a review of Resident 3's History and Physical (H&P), dated 9/6/2024, the H&P indicated the resident was alert and oriented to person and the resident had the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 12/15/2024, the MDS indicated the resident usually make self-understood and understand others and the resident had moderate cognitive impairment (a person experiences noticeable difficulties with thinking, learning, remembering, and making decisions, but they are still able to manage their daily activities, though with some challenges). During a review of Resident 3's Progress Notes, dated 8/25/2024, the Progress Notes by Licensed Vocational Nurse (LVN) 2, at 6:27 a.m., indicated the resident was sent out to the hospital. During a review of Resident 3's Discharge Summary Report, dated 8/25/2024, the Discharge Summary Report indicated the resident was transferred to acute care hospital for elevated WBC to be evaluated for acute renal failure (when the kidneys suddenly cannot filter waste products from the blood) and infection. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/13/2025, at 11:10 a.m., with Registered Nurse (RN) 1, reviewed Resident 3's Change of Condition Reports, Discharge Summary Report, and Notice of Proposed Transfer/Discharge. RN 1 stated she cannot find any Change of Condition Report done by licensed nurses on 8/25/2024. RN 1 stated the licensed nurse who discharged the resident to the acute care hospital should have done a change of condition report to document the incident to communicate the event to other healthcare providers to ensure appropriate care was provided to the resident. During an interview on 3/14/2025, at 11:37 a.m., with the Director of Nursing (DON), inside the facility's conference room, the DON stated the licensed staff should have created a change of condition report for Resident 3, who went to the hospital on 8/25/2024 due to elevated WBC to document the events that happened, and the interventions provided to the resident prior to transfer to communicate to all healthcare team and the family. During a review of the facility's recent policy and procedure (P&P) titled Acute Condition Changes- Clinical Protocol, last reviewed on 9/27/2024, the P&P indicated the physician will help identify individuals with a significant risk for having acute changes of condition during their stay; for example, an individual with an indwelling urinary catheter who has had recurrent symptomatic urinary tract infections, or someone with unstable vital signs or recurrent pneumonia. In addition, the nurse shall assess and document/report the following baseline information: a. Vital signs; b. Neurological status; c. Current level of pain, and any recent changes in pain level; d. Level of consciousness; e. Cognitive and emotional status; f. Resident's age and sex; g. Onset, duration, severity; h. Recent labs; i. History of psychiatric disturbances, mental illness, depression, etc.; j. All active diagnoses; and k. All current medications. Before contacting a physician about someone with an acute change of condition, the nursing staff will collect pertinent details to report to the physician; for example; the history of present illness and previous and recent test results for comparison. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Phone calls to attending or on-call physicians should be made by an adequately prepared nurse who has collected and organized pertinent information, including the resident/patient's current symptoms and status.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38552 4. During a review of Resident 4's Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/13/2017 and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), hypertension (HTN-high blood pressure), and type II diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 4's Fall Risk Assessment, dated 2/27/2025, the Fall Risk Assessment indicated the resident as high risk for falls and care plan will be developed to reduce falls and injuries. During a review of Resident 4's physician order, dated 2/28/2025, the physician order indicated low bed with bilateral upper siderails up with bilateral floor mats to decrease potential injury due to unpredictable related to dementia. During a review of Resident 4's Care Plan (CP) Report focus on falling star program, dated 3/3/2025, the CP Report indicated interventions including floor mats. During a review of Resident 4's MDS, dated [DATE], the MDS indicated the resident was rarely/never makes self-understood, rarely/never had the ability to understand others, and had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated the resident was totally dependent on staff with all ADLs and functional mobility including rolling left and right, sitting to lying, and lying to sitting on side of bed. During a review of Resident 4's H&P, dated 3/5/2025, the H&P indicated the resident did not have the capacity to make medical decision at this time. During an observation on 3/11/2025 at 8:39 a.m., while inside Resident 4's room, Resident 4 lying in bed, asleep. A wheelchair was observed on top of Resident 4's right side floor mat. The overbed table was on top of the resident's left side floor mat. During an observation on 3/12/2025 at 4:33 p.m., while inside Resident 4's room, Resident 4 was lying in bed, asleep. A wheelchair was observed on top of the resident's right side floor mat and the resident's overbed table on top of the resident's left side floor mat. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/13/2025 at 7:58 a.m. with Certified Nursing Assistant (CNA) 4, while inside Resident 4's room, Resident 4 was observed lying in bed. CNA 4 stated the wheelchair was on top of the resident's right side floor mat and overbed table and the laundry hamper had soiled clothes on top of the resident's left side floor mat. CNA 4 stated she had not touched the wheelchair it has been there since she clocked in. CNA 4 stated she does not know if it's okay to have items/equipment on top of the resident's floor mats, but she knows the purpose of the floor mats was to prevent the resident from falling directly on the floor because the resident is a fall risk. CNA 4 stated the resident is dependent in turning while in bed and transferring in and out of bed. During an interview on 3/14/2025 at 10:44 a.m. with MDS Nurse (MDSN) 1, MDSN 1 stated Resident 4 is totally dependent on functional mobility and on transfers and repositioning. MDSN 1 stated the floor mat is one of the interventions implemented for residents who are high risk for falls. MDSN 1 stated the facility's floor mat is cushioned, and it helps prevent injury to the resident when they fall from bed to the floor, which is a hard surface . During an interview on 3/14/2025 at 7:38 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the resident's floor mats are to minimize the impact on the floor when resident falls. LVN 1 stated the fall mat should not have anything on top of it because it defeats the purpose of preventing injury to the resident. LVN 1 stated the resident could fall and hit themselves on the wheelchair. During an interview on 3/14/2025 at 2:53 p.m. with the DON, the DON stated they assess for resident's who really need it and for them to prevent severe injury when they roll out from the bed. The DON stated the floor mats are placed at the resident's bedside and ensure the overbed table is within the resident's reach. The DON stated Resident 4 is totally dependent on staff with ADLs and mobility so they would need to reassess if floor mats are still needed . During a review of the facility's P&P, titled Safety and Supervision of Residents, last reviewed on 9/27/2024, the P&P indicated the facility strives to make the environment as free from accident hazards as possible. The P&P indicated resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The P&P indicated implementing interventions to reduce accident risks and hazards include ensuring that interventions are implemented and documenting interventions. During a review of the facility's P&P titled, Falls and Fall Risk Managing, last reviewed on 9/27/2024, the P&P indicated based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling; Environmental factors that contribute to the risk of falls include obstacles in the footpath. 43988 2&3. During a review of Resident 272's Admission Record, the Admission Record indicated the facility admitted the resident on 3/3/2025 with diagnoses that included a fall, difficulty in walking, and generalized muscle weakness. During a review of Resident 272' Order Summary Report, the Order Summary Report indicated the following physician's orders dated 3/4/2025: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Low bed with bilateral upper siderails up with bilateral floor mats to decrease potential injury due to unpredictable movement/behavior every shift. - Tab alarm on when in bed and wheelchair to remind resident to call for assistance due to history of frequent falls. During a review of Resident 272's fall risk assessment dated [DATE], the fall risk assessments indicated the resident was a high risk for falls. During a review of Resident 272's H&P, dated 3/5/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 272's care plan (CP) titled, Expected Behavior related to Movement to Floor Mat, initiated on 3/9/2025, the CP included interventions to continue with a low bed with a floor mat, tab alarm to remind resident to stop and ask for assistance, and a bed or chair alarm to minimize risk of injury. During a review of Resident 272's MDS, dated [DATE], the MDS indicated the resident had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and required substantial/maximal assistance to total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 272 had a history of falls in the last six months. During an observation on 3/11/2025 at 9:37 a.m. while inside Resident 272's room, Resident 272 was observed with an overbed table placed on top of the left floor mat, the right floor mat was placed halfway underneath the bed with the right wheel at the foot of the bed placed on top of it, and there was no bed alarm placed. During a concurrent observation and interview on 3/11/2025 at 11:37 a.m. while inside Resident 272's room with the Infection Preventionist (IP), the IP stated the left floor mat had the overbed table placed on top of it, the right floor mat was placed halfway underneath the bed with the right wheel at the foot of the bed placed on top of it, and there was no bed alarm placed. The IP stated any type of equipment should not be placed on top of the floor mat and the floor mat should be placed appropriately on the side of the bed not under the bed. The IP stated any heavy equipment placed on top of the floor mat and not placed appropriately can affect the integrity of the floor mat which defeats the purpose of providing safety for the resident during falls. The IP stated tab alarms are provided to residents who are high risk and had a history of recent falls to alert the residents to ask for help. The IP stated Resident 272's tab alarm should have been applied as ordered by the physician. The floor mats should be placed appropriately, and no heavy equipment should be on top of them for Resident 272's safety in the event of falls which may cause injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/13/25 at 10:48 a.m. with RN 1, RN 1 stated residents are assessed for fall risk upon admission, quarterly, and as needed and interventions are implemented as needed. RN 1 stated if a resident is a high risk during the assessment, the facility will place the resident on the falling star program and implement appropriate interventions such as floor mats and tab alarm when in bed to reduce risk of falls which can cause injury. RN 1 stated there should be no heavy equipment on top of the floor mat such as the wheels of the bed frame and overbed table as the equipment can affect the integrity of the floor mat. RN 1 stated the presence of hazards or clutter in the room injure a resident in the event of a fall when they hit the equipment next to the bed. RN 1 stated Resident 272's overbed table should not have been placed on the left floor mat and the right floor mat should have been placed on the side of the bed away from the wheel for Resident 272's safety to prevent injury when the resident falls out of bed and hit the table or the floor. During a review of the facility's P&P titled Safety and Supervision of Residents, last reviewed on 9/27/2024, the P&P indicated: - The facility strives to make the environment as free from accident hazards as possible. - Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. - Implementing interventions to reduce accident risks and hazards include ensuring that interventions are implemented and documenting interventions. During a review of the facility's P&P titled, Falls and Fall Risk Managing, last reviewed on 9/27/2024, the P&P indicated: - Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. - Environmental factors that contribute to the risk of falls include obstacles in the footpath. - Position change alarms will not be used as the primary or sole interventions to prevent falls, but rather will be used to assist the staff in identifying patterns and routines to the resident. The use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner. 44244 5. During a review of Resident 70's Admission Record, the Admission Record indicated the facility admitted the resident on 10/13/2020 and readmitted the resident on 2/14/2025 with diagnoses that included metabolic encephalopathy (a change in the brain function due to injury or disease), lack of coordination, and dementia (a progressive state of decline in mental abilities). During a review of Resident 70's H&P, dated 2/17/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 70's MDS, dated [DATE], the MDS indicated the resident was rarely/never able to understand others and was rarely/never able to make herself understood. The MDS indicated the resident was dependent on assistance from staff for toileting, dressing, personal and oral hygiene, bathing, and mobility. During an observation on 3/11/2025 at 12 p.m., Resident 70 lay in bed awake. Resident 70 did not respond to the surveyor. To the left of the resident's bed, there was a large window extending down to the floor. Under the window, a baseboard was removed from the wall with a large metal nail extending approximately one inch out of the board outward toward the room and next to Resident 70's wheelchair. The windowsill was broken with jagged, splintering wood. Under the windowsill and next to the broken baseboard, there was dirt and numerous pieces of broken concrete. CNA 2 entered Resident 70's room, assessed the resident's window and stated the windowsill and baseboard were broken with pieces of concrete and a nail. CNA 2 stated CNA 2 was not assigned to care for Resident 70 and was not aware of the broken baseboard and windowsill. CNA 2 was observed to exit Resident 70's room. During a concurrent interview and observation on 3/11/2025 at 12:15 p.m. with CNA 3, CNA 3 entered Resident 70's room and assessed the baseboard and windowsill. CNA 3 stated she was assigned to care for Resident 70 and CNA 3 was not previously aware of the broken baseboard and pieces of concrete. CNA 3 exited Resident 70's room. During a concurrent interview and observation on 3/12/2025 at 7:56 a.m., with the Assistant Director of Staff Development (ADSD), the ADSD entered Resident 70's room and assessed the baseboard and windowsill. The ADSD stated the window baseboard was broken with two nails sticking out and there was broken concrete pieces behind the baseboard. The ADSD stated the broken baseboard and windowsill did not look safe and should not be like that. The ADSD stated the nails could be a danger to any resident passing by. During a concurrent observation and interview on 3/12/2025 at 8 a.m., with the Maintenance Director (MD), the MD entered Resident 70's room and stated a week prior to 3/12/2025 the MD was replacing the baseboards in Resident 70's room and discovered the concrete needed to be repaired. The MD stated he left the broken board with two nails sticking out, broken windowsill, and pieces of concrete in the resident's room for about one week while waiting to do the repairs. The MD stated the MD did not think the environment was unsafe for the resident. During a concurrent observation and interview on 3/12/2025 at 8:05 a.m., with the DON, the DON reviewed the facility policy regarding resident supervision. The DON observed Resident 70's room and stated the DON was not aware of the broken baseboard with nails, broken windowsill, and pieces of broken concrete at the resident's bedside. The DON stated the resident's room had hazards and should have been reported and corrected immediately, but it was not. The DON stated there was a potential that Resident 70 could get an abrasion from the nail on the board while transferring to the wheelchair. The DON stated the facility policy was not followed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility P&P titled, Safety and Supervision of Residents, last reviewed 9/27/2024, the policy indicated the facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents. [Cross reference F584] 6. During a review of Resident 13's Admission Record, the Admission Record indicated the facility admitted the resident on 6/26/2016 and readmitted the resident on 9/5/2019 with diagnoses that included dementia, muscle weakness, pressure induced deep tissue damage of the sacral region (region at the bottom of the spine lying and tailbone), and history of falling. During a review of Resident 13's CP titled, Resident is at risk for falls/injury ., initiated 9/27/2024, the CP indicated to provide the resident with a safe environment. During a review of Resident 13's H&P, dated 12/9/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 13's MDS dated [DATE], the MDS indicated the resident was rarely/never able to understand others and was sometimes able to make herself understood. The MDS indicated the resident was dependent on assistance from staff for toileting, dressing, personal and oral hygiene, bathing, and rolling from left to right side. During a review of Resident 13's CP titled, Falling Star Program ., initiated 1/7/2025, the CP indicated an intervention for a low bed with floor mats to decrease the potential for injury due to unpredictable movement related to dementia. During a review of Resident 13's Order Summary Report, the Order Summary Report indicated the following orders: -Low bed with bilateral (both sides) upper (located at the chest and shoulders) half siderails (adjustable rigid plastic bars attached to the bed that may be positioned in various locations) up with floor mat to decrease the potential injury due to unpredictable movement related to dementia, dated 2/17/2024. - Medi honey wound dressing external gel (topical wound and burn medication made from honey), apply to Sacro coccyx topically everyday shift for pressure injury for 30 days. Cleanse with normal saline (NS, a mixture of water and salt), pat to dry, and cover with foam dressing, dated 3/3/2025. - Vitamins A&D external ointment (topical medication for the skin), apply to left heel topically every day shift for skin maintenance cleanse with NS, pat dry, and leave open to air, dated 11/11/2024. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Diclofenac arthritis pain external gel (topical medication for pain), apply to bilateral shoulders topically every day and evening shift for pain management apply 2 grams (GM, a unit of measurement), dated 10/30/2024. During a wound care observation on 3/13/2025 at 9:36 a.m., Treatment Nurse (TN) 1 provide wound care for Resident 13. TN 1 closed Resident 13's privacy curtains and adjusted the bed to the highest elevated position. TN 1 assisted the resident to lay on the left side with the resident holding the left upper half side rail. The resident was able to move her legs. TN 1 removed Resident 13's soiled dressing on the sacral region. TN 1 removed his dirty gloves and walked to the restroom to wash his hands. TN 1 left Resident 13 unattended and not visible with the bed in the high elevated position. TN 1 returned and performed the wound care to the sacral region. TN 1 walked to the bathroom to wash TN 1 hands while leaving Resident 13 unattended and not visible with the bed in the high elevated position at the following times: - after cleansing Resident 13's sacral wound with NS. - after applying Resident 13's sacral dressing. - after cleansing Resident 13's left heel with NS. - after applying A&D ointment to Resident 13's left heal. During a follow up interview immediately upon exiting Resident 13's room on 3/13/2025 at 10:05 a.m., with TN 1, TN 1 stated Resident 13 is able to move a bit, and the resident was compliant with the treatment but confused. TN 1 stated the facility policy is to wash his hands between every dirty and clean procedure during wound care. TN 1 stated he placed Resident 13's bed in the high position and closed the privacy curtain. TN 1 stated he went to the restroom multiple times during Resident 13's wound care treatment and was not able to see the resident because the curtain was closed. TN 1 stated it was not okay to leave Resident 13 unattended with the bed in the high position because the resident may move and fall off the bed causing an injury. TN 1 stated TN 1 usually brings a CNA to assist with wound care, but all the CNAs were busy. During an interview on 3/14/2025 at 9:35 a.m., with the DON, the DON reviewed the facility policy regarding resident supervision. The DON stated during wound care treatment the TN should have a CNA assisting to ensure safety with turning the resident. The DON stated Resident 13 is able to wiggle and the resident is unpredictable. The DON stated Resident 13 should not be left unattended with the bed in the high position because the resident could roll off the bed resulting in injury. The DON stated TN 1 could have taken a CNA into the room, placed the bed in the low position when washing his hands, or taken antibacterial hand rub to bedside while providing wound care; but he did not. The DON stated the facility policy was not followed when TN 1 left Resident 13's bed in the high position while he left the resident to wash his hands. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility P&P titled, Safety and Supervision of Residents, last reviewed 9/27/2024, the policy indicated the facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents. During a review of the facility P&P titled, Fall and Fall Risk, Managing, last reviewed 9/27/2024, the policy indicated staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Environmental factors that contribute to the risk of falls include incorrect bed height. Resident conditions that may contribute to the risk of falls include cognitive impairment and functional impairments. 44376 Based on interview, and record review, the facility failed to ensure the resident environment was free of accident hazards for two of five sampled residents (Resident 272 and 4) reviewed for accident care area by failing to: 1. Ensure Resident 88's bilateral fall mat (a cushioned mat that reduces the risk of injury from a fall) did not have a furniture or equipment on top of them. 2. Ensure Resident 272's floor mats did not have equipment placed on top of them and were placed appropriately. 3. Ensure Resident 272's bed tab alarm (a device that triggers an audible alarm when a patient attempts to rise off the pad) was placed as ordered by the physician. 4. Ensure Resident 4 did not have a wheelchair and overbed table on top of the resident's bilateral floor mats. These deficient practices placed Residents 88, 272, and Resident 4 at risk for increased chances of incurring injury such as falls with fracture (bone that is broken in at least two places) and even death. 5. Ensure windowsills and baseboards were in good repair and free from sharp nails and jagged, splintering wood for one of six sampled residents (Resident 70) reviewed under the Environment task. This deficient practice had the potential to result in resident injuries like lacerations. 6. Ensure residents were not left unattended by staff with the bed in the high position for one of two sampled residents (Resident 13) reviewed under the Pressure Ulcer (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) care area. These deficient practices had the potential to result in resident falls resulting in injuries like fractures and lacerations. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. During a review of Resident 88's Admission Record, the Admission Record indicated the facility admitted the resident on 2/19/2023, with diagnoses of history of falling, age-related physical debility (decline in physical function and strength that makes older adults more vulnerable to illness, falls, and other problems), and history of traumatic fracture (a broken bone caused by a sudden, forceful impact or injury, like a fall, car accident, or sports injury, rather than from a disease or weakness in the bone itself). During a review of Resident 88's History and Physical (H&P), dated 3/5/2025, the H&P indicated the resident was on fall precaution (taking steps to prevent someone from falling or minimize the risk of injury if a fall does occur). The H&P indicated the resident did not have the capacity to make medical decisions. During a review of Resident 88's Minimum Data Set (MDS, a resident assessment tool), dated 2/23/2025, the MDS indicated the resident usually had the ability to make self-understood and understand others and had severely impaired cognition (they have trouble with things like memory or paying attention). The MDS indicated the resident required substantial to supervision assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 88's Order Summary Report, the Order Summary Report indicated an order for: 1/8/2025 [FALLING STAR] Resident placed on falling star program related to high-risk score on fall risk assessment. 1/7/2025 [RESTRAINT] Low bed (a bed frame or mattress set that sits closer to the floor than a standard bed, often with a minimalist and modern design, and typically doesn't require a box spring) with bilateral upper siderails up (horizontal bars attached to the sides of a bed), with bilateral floor mats to decrease potential injury due to unpredictable movement related to dementia (a progressive state of decline in mental abilities) every shift. During a review of Resident 88's Fall Risk Assessment, dated 2/22/2025, the Fall Risk Assessment indicated the resident was high risk for falls. During a review of Resident 88's Care Plan (CP) titled Resident is at risk for falls/injury related to aging process, limited mobility, unsteady balance etc., last revised on 12/4/2024, the CP indicated an intervention to promote safe environment, low bed, side rails as enabler, and floor mats. The CP also indicated an intervention to provide the resident with a safe and clutter-free environment. During a concurrent observation and interview on 3/12/2025, at 9:55 a.m., with the Assistant Director of Staff Development (ADSD), inside Resident 88's room, observed Resident 88 had bilateral fall mats on, the right fall mat had a wheelchair and a side table on top of them, while at the left fall mat had a visitor chair on top of them. The ADSD stated there should be no furniture or medical equipment on top of Resident 88's fall mats because the resident can fall on them and cause injury to the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/13/2025, at 10:48 a.m., with Registered Nurse (RN) 1, RN 1 stated there should be no furniture or medical equipment on top of Resident 88's fall mats because the resident can fall on them and cause injuries such as head bumps, fracture (broken bone), skin lacerations (a tear or cut in the skin, often with jagged or irregular edges, caused by a sharp object or blunt force) and cuts. RN 1 also stated leaving heavy medical equipment on top of the fall mats can cause tears and creates a permanent dent on the fall mat decreasing the ability of the mat to lessen the impact of the fall. During an interview on 3/14/2025, at 11:37 a.m., with the Director of Nursing (DON), inside the facility's conference room, the DON stated there should be no furniture or equipment on top of Resident 88's bilateral fall mat for patient safety. The DON stated placing furniture and medical equipment on top of the fall mat could trip the patient when the resident gets out of the bed that can cause injuries such as fractures and lacerations. The DON added they will figure out in the facility where to store extra items to declutter the resident's environment. During a review of the facility's recent policy and procedure (P&P) titled Falls and Fall Risk, Managing, last reviewed on 9/27/2024, the P&P indicated based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from failing and to try to minimize complications from falling. Environmental factors that can contribute to the risk of falls include: d. obstacles in the footpath. During a review of the facility's recent P&P titled Homelike Environment, last reviewed on 9/27/2024, the P&P indicated residents are provided with a safe, clean, comfortable and home like environment and encouraged to use their personal belongings to the extent possible. During a review of the facility's recent P&P titled Safety and Supervision of Residents, last reviewed on 9/27/2024, the P&P indicated our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. During a review of the facility-provided National Falls Toolkit titled Floor Mat Resource and Implementation Guide, undated, the National Falls Toolkit indicated furniture near the head of the bed should be placed with care and sharp edges should be padded for persons likely to fall from bed.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 43988 Based on observation, interview, and record review, the facility failed to ensure residents with a urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) received appropriate care and services to prevent urinary tract infections (UTI, an infection in the bladder/urinary tract) for two of two sampled residents (Residents 272 and 371) reviewed for urinary catheter or UTI by failing to ensure Residents 272's and 371's urinary catheter tubing did not have a loop while hanging on the side the bed. This deficient practice had the potential for the resident's urine not to flow freely which may lead to development of UTI. Findings: a. During a review of Resident 272's Admission Record, the Admission Record indicated the facility admitted the resident on 3/3/2025 with diagnoses including obstructive and reflux uropathy (a condition where urine flow is blocked in the urinary tract causing the urine to back up and damage the kidneys), difficulty in walking, and generalized muscle weakness. During a review of Resident 272's Order Summary Report, the Order Summary Report indicated the following physician's orders dated 3/4/2025: - Secure suprapubic catheter (a thin, flexible tube inserted directly into the bladder through a small incision in the lower abdomen, used to drain urine) tubing with anchor everyday shift to minimize dislodging of catheter. - Change suprapubic catheter as needed when clogged, soiled, or pulled out. - Suprapubic catheter care everyday shift. - Suprapubic catheter French (Fr - a unit of measurement) 22 per ten (10) milliliters (ml - a unit of measurement) attached to bedside drainage bag due to obstructive uropathy. During a review of Resident 272's History and Physical (H&P) dated 3/5/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 272's Minimum Data Set (MDS, a resident assessment tool), dated 3/10/2025, the MDS indicated the resident had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and substantial/maximal assistance to total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 272 had history of falls in the last six months. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 272's care plan (CP) on alteration in urinary elimination and risk for UTI initiated on 3/9/2025, the CP indicated to maintain proper alignment of the resident's indwelling (Foley) catheter to promote proper drainage as one of the interventions to reduce the risk of infection daily. During an observation on 3/11/2025 at 9:37 a.m., while inside Resident 272's room, Resident 272 was observed lying in bed asleep with a urinary catheter draining to a drainage bag with the tubing coiled at the lower end part of the tubing and urine in the tubing. During a concurrent observation and interview on 3/11/2025 at 11:37 a.m., while inside Resident 272's room with the IP, the IP stated Resident 272's urinary catheter tubing had a loop towards the lower end of the tubing with urine inside the tubing. The IP stated urinary catheters should be placed in a position that the urine will drain freely such as no kinks or loops and can cause the urine to backflow which may lead to a UTI. The IP stated Resident 272's urinary catheter tubing should have no loop or kinks so the urine can flow freely and prevent development of urine infection. During an interview on 3/13/2025 at 11:20 a.m. with Registered Nurse (RN) 1, RN 1 stated urinary catheters are required to be placed in a position that the urine will drain freely. RN 1 stated the tubing should have no kinks or loops while hanging on the side of the bed as it can cause the urine to backflow into the bladder which may lead to development of urine infection. RN 1 stated Resident 272's urinary catheter tubing should have no loops or kinks so the urine can flow freely and prevent development of a urine infection. During a review of the facility's recent policy and procedure (P&P) titled Catheter Care, Urinary, last reviewed on 9/27/2024, the P&P indicated the purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. The P&P further indicated: - Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks. - Check drainage tubing and bag to ensure that the catheter is draining properly. 44376 b. During a review of Resident 371's Admission Record, the Admission Record indicated the facility admitted the resident on 3/11/2025, with diagnoses of benign prostatic hyperplasia (a common condition in men where the prostate gland grows larger than normal, but not due to cancer, potentially causing urinary problems) and obstructive and reflux uropathy (a condition in which the flow of urine is blocked). During a review of Resident 371's H&P, dated 2/28/2025, the H&P indicated the resident was awake, responsive, in no acute distress and the resident's mood (sustained, underlying emotional state, like the general climate of feelings) and affect (is the outward expression of those emotions, like the weather a person display) were intact. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 371's Order Summary Report, dated 3/12/2025, the Order Summary Report indicated an order for foley catheter (a medical device that helps drain urine from your bladder) care every day shift and foley catheter French (Fr) (18)/(10) milliliters (ml, a unit of volume) attached to bedside drainage bag due to obstructive uropathy every shift. During a review of Resident 371's Care Plan (CP) titled Alteration in urinary elimination and at risk for UTI secondary to use of foley catheter, last revised on 3/13/2025, the CP indicated an intervention to maintain proper alignment of foley catheter to promote proper drainage. During a concurrent observation and interview on 3/12/2025, at 8:35 a.m., with Certified Nursing Assistant (CNA) 1, inside Resident 371's room, observed Resident 371's urinary catheter tubing coiled not promoting proper drainage. CNA 1 stated Resident 371's urinary catheter tubing should not be coiled to prevent backflow of urine to the bladder causing infection. During an interview on 3/13/2025, at 11:20 a.m., with RN 1, RN 1 stated there should be no loops on Resident 371's urinary catheter tubing to prevent backflow of urine that can cause UTI. During an interview on 3/14/2025, at 11:37 a.m., with the Director of Nursing (DON), inside the facility's conference room, the DON stated Resident 371's urinary catheter tubing should not have loops on them because it can cause urine reflux or backflow to the bladder causing UTI. During a review of the facility's recent P&P titled Catheter Care, Urinary, last reviewed on 9/27/2024, the P&P indicated the purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks. Check drainage tubing and bag to ensure that the catheter is draining properly.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 38552 Based on observation, interview, and record review, the facility failed to implement interventions consistent with the resident's assessed needs and goals to maintain acceptable parameters of nutritional for one of four sampled residents (Resident 42) by failing to provide Ensure (a nutritional supplement) to Resident 42 as ordered. This deficient practice had the potential to place Resident 42 at further risk of weight loss. Findings: During a review of Resident 42's Admission Record, the Admission Record indicated the facility originally admitted the resident on 6/30/2019 and readmitted the resident on 4/20/2024 with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), chronic pain syndrome (pain that lasts longer than three months), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) without dyskinesia (involuntary, erratic, writhing movements of the face, arms, legs or trunk). During a review of Resident 42's physician order, dated 8/9/2024, the physician order indicated to give Ensure two times a day. During a review of Resident 42's History and Physical (H&P), dated 12/10/2024, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 42's Minimum Data Set (MDS-a resident assessment tool), dated 1/26/2025, indicated the resident had the ability to make self understood and understand others. The MDS indicated the resident had more than five (5) percent (%-a unit of measurement) or more in the last month or loss of 10% in last six (6) months and not on physician-prescribed weight-loss regimen. During an observation and interview on 3/11/2025 at 11:10 a.m. with Resident 42, while inside Resident 42's room, there was no Ensure was observed. Resident 42 stated he used to be 195 pounds (lbs-a unit of measurement) when he first came to the facility and now, he is down to 144 lbs. Resident 42 stated he eats large portion meals and the Ensure drink. Resident 42 stated he does not see his Ensure on his table. Resident 42 stated someone usually brings it to him in the morning after breakfast but before his lunch. During an interview on 3/11/2025 at 11:30 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she has not given Resident 42 his Ensure drink and she will go to the kitchen to get it. LVN 1 stated usually restorative nursing assistants would pass the snacks, but the resident's Ensure was not included. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/11/2025 at 2:45 p.m. with LVN 1, LVN 1 stated Resident 42 has an order for Ensure to be given twice a day scheduled at 10 a.m. and 2 p.m. LVN 1 stated the resident receives Ensure drink because resident was losing weight and if it's not given the resident could potentially lose more weight. LVN 1 stated she missed giving it to the resident on 3/11/2025 and she corrected it and gave the Ensure to the resident right after. During an interview on 3/14/2025 at 2:43 p.m. with the Director of Nursing (DON), the DON stated the Ensure requires a doctor's order and should be given to the resident as ordered. During a review of the facility's policy and procedure (P&P) titled, Physician Orders and Telephone Orders, last reviewed on 9/27/2024, the P&P indicated physician's orders are in effect for 45 days from the date of the physician's signature unless otherwise specified. The P&P indicated all orders must be specific and complete with all necessary details to carry out the prescribed order without any questions. During a review of the facility's P&P titled, Snacks (Between Meal and Bedtime), Serving, last reviewed on 9/27/2024, the P&P indicated the purpose of this procedure is to provide the resident with adequate nutrition. The P&P indicated the person performing this procedure should record the following information in the resident's medical record including the date and time the snack was served, the name and title of the person who served the snack, the amount of snack eaten by the resident, if the resident refused the snack, the reason(s) why and the intervention taken, and the signature and title of the person recording the data.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 43988 Based on observation, interview, and record review, the facility failed to ensure parenteral fluids (are liquids that are administered intravenously or by injection to bypass the digestive system) were administered consistent with professional standards of practice for two (2) of 2 sampled residents (Residents 269 and 15) reviewed during a random observation by: 1. Failing to change the loose and soiled dressing on Resident 269 right upper arm (RUA) peripherally inserted central line catheter (PICC line - a long, thin tube inserted through a vein in the arm and passed through to the larger veins near the heart used for long-term intravenous access) as observed on 3/11/2025 at 9:10 a.m. 2. Failing to place a sterile injection cap over the injection port of Resident 15's peripheral intravenous line (PIV - a soft, flexible tube placed inside a vein, usually in the hand or arm to give a person medicine or fluids). These deficient practices had the potential to place Residents 269 and 15 at risk for developing complications such as inflammation of the vein and infection. Findings: a. During a review of Resident 269' Admission Record, the Admission Record indicated the facility admitted the resident on 3/1/2025 with diagnoses including osteomyelitis of lumbar region (a bone infection in the lower back spine, often caused by bacteria, that can lead to pain, fever, and potentially serious complications if left untreated), anxiety disorder (a mental health condition characterized by persistent and intense feelings of worry, fear, and apprehension), and difficulty in walking. During a review of Resident 269's Minimum Data Set (MDS, a resident assessment tool), dated 3/7/2025, the MDS indicated the resident had an intact cognition (mental action or process of acquiring knowledge and understanding) and required substantial/maxial assistance from staff with lower body dressing, supervision/touching assistance with eating and oral hygiene; partial/moderate assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 269 received IV antibiotic (a type of medicines that fight bacterial infections) medications. During a review of Resident 269's Order Summary Report, the Order Summary Report indicated the following physician's orders: - 3/1/2025: PICC line care: every day shift every seven (7) day) for site care, change all transparent dressings per sterile technique (upon admission if not dated or site not visible for assessment) as needed for wet, loose or soiled dressing. - 3/1/2025: PICC line care: as needed for wet, loose or soiled dressings. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 269's care plan (CP) on potential for infection and /or complications related to central venous catheter initiated on 3/3/2025 and last revised 3/11/2025, the CP indicated to change all dressing every 7 days and as needed when wet, loose or soiled dressing as of the interventions to maintain the central venous catheter free from infections. During an observation on 3/11/2025 at 9:10 a.m. inside Resident 269's room, observed Resident 269 lying in bed awake, alert, and responds appropriately with an IV access on the RUA and the transparent dressing was loose and soiled. Resident 269 stated he had a shower the day before and the dressing became loose. During a concurrent observation and interview on 3/11/2025 at 9:27 a.m., inside Resident 269's room with Registered Nurse (RN) 1, RN 1 stated Resident 269's had a PICC line and that the transparent dressing was loose and soiled. RN 1 stated PICC line dressing changes are supposed to be done by the RN every 7 days and as needed if soiled, loose, or leaking. RN 1 stated RNs are supposed to assess the site every shift for signs and symptoms of infection, swelling, leakage, soiled, and loose dressing. RN 1 stated Resident 269's PICC line dressing should have been changed when the night shift RN hang the new bag of IV antibiotic at 7 a.m. as it placed Resident 269 at risk for development of infection on the insertion site which may lead to more complications such as hospitalization . During an interview 3/14/2025 at 2:30 p.m., with the Director of Nursing (DON), the DON stated PICC line dressing changes are supposed to be done by the RN every 7 days and as needed if soiled, loose, or leakage. The DON stated RNs are supposed to assess the site every shift for signs and symptoms of infection, swelling, leakage, soiled, and loose dressing. the DON stated Resident 269's PICC line dressing should have been changed when they observed the dressing was loose and soiled during assessment as it placed Resident 269 at risk for development of infection on the insertion site which can lead to hospitalization . During a review of the facility's policy and procedure titled, Peripheral and Midline IV Dressing Changes, last reviewed on 9/27/2024, the P&P indicated a purpose to prevent complications associated with intravenous therapy, including catheter-related infections associated with contaminated. Loosened or soiled catheter-site dressings. The P&P further indicated: - Perform site care and dressing change at established intervals or immediately of the integrity of the dressing is compromised (such as damp, loosened, or visibly soiled). - Change the dressing if it becomes damp, loosed, or visibly soiled and: a. At least every 7 days for transparent dressing. b. Immediately if the dressing or sit appears compromised. b. During a review of Resident 15' Admission Record, the Admission Record indicated the facility originally admitted the resident on 10/11/2023 and readmitted in the facility on 12/11/2024 with pneumonia (an infection/inflammation in the lungs), Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 15's History and Physical (H&P) dated 12/14/2024, the H&P indicated Resident 15 had the capacity to understand and make decisions. During a review of Resident 15's Minimum Data Set (MDS, a resident assessment tool), dated 12/19/2024, the MDS indicated the resident had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and required setup or clean-up assistance with eating; partial/moderate assistance with oral hygiene and upper body dressing; substantial/maximal assistance with toileting hygiene and lower body dressing; total assistance with bathing; refused to participate with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 15's Order Summary Report, the Order Summary Report indicated the following physician's orders dated 3/6/2025: - PIV flush order: flush with then (10) milliliter (ml - a unit of measurement) normal saline (NS) before and after IV medications. Maintenance: Flush with 10 ml NS 2 times a day. - Peripheral Site Care as needed for complications may extend IV site for poor venous access if no complications are present. Change dressing with site change and as needed. During concurrent interview and record review on 3/11/2025 at 11:30 a.m. inside Resident 15's room with RN 1, RN 1 stated Resident 15 had a PIV access on the left hand wrapped with gauze and the needleless injection port did not have a sterile injection cap over it. RN 1 stated any IV access with needleless injection ports should be covered with a sterile injection cap after each use. RN 1 state Resident 15's PIV needleless injection port should haven been covered with the sterile injection cap after it was used to prevent infection of the PIV site which may lead to more complications such as hospitalization . During an interview on 3/14/2025 at 2:47 p.m. with the DON, the DON stated RNs are responsible to make sure that the needleless injection port for any IV access should have a sterile injection cap placed after every use. The DON stated the RNs should have place a sterile injection cap over Resident 15's needleless injection port after use to prevent development of infection from the contaminated injection port which can cause more complications such as extension of the course of antibiotic. During a review of the facility provided manufacturer's guideline for Disinfecting Cap Strip (DCS), dated 2016, the manufacturer's guideline indicated the DCS is: - Intended for use on needleless connectors as a disinfecting cleaner prior to IV access and to act as a cover between line accesses. - The cap will disinfect the needleless connector one (1) minute after application and protect from contamination between accesses for up to 7 days if not remove. - New cap should be placed on needleless connector after each use.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38552 2. During a review of Resident 70's Admission Record, the Admission Record indicated the facility originally admitted the resident on 10/13/2020 and readmitted on [DATE] with diagnoses including metabolic encephalopathy (a condition where the brain does not work normally because of problems with the body's metabolism [how the body manages food, energy, or chemicals]), and sepsis (a life-threatening blood infection), and dementia (a progressive state of decline in mental abilities). During a review of Resident 70's Order Summary Report (OSR), dated 2/14/2025, the OSR indicated Administer O2 at two liters per minute (LPM- a unit of measurement) via nasal cannula. May titrate up to five (5) LPM for O2 saturation less than 90 percent (%- a unit of measurement) as needed for shortness of breath. During a review of Resident 70's H&P, dated 2/17/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 70's MDS, dated [DATE], the MDS indicated the resident had unclear speech, rarely/never makes self-understood, rarely/never had the ability to understand others, and had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. During an observation on 3/11/2025 at 9:23 a.m., while inside Resident 70's room, Resident 70 was on oxygen therapy using a nasal cannula. During an observation on 3/12/2025 at 12:04 p.m., while inside Resident 70's room, Resident 70 was on oxygen therapy at 2 LPM via nasal cannula. During a concurrent observation and interview on 3/12/2025 at 2:22 p.m. with CNA 6, while inside Resident 70's room at bedside, CNA 6 stated Resident 70 was on oxygen at 2 LPM using a nasal cannula. CNA 6 stated Resident 70 has been on oxygen all day and she does not touch the oxygen machine. During an interview on 3/12/2025 at 2:24 p.m. with RN 1, RN 1 stated before the licensed nurse administers the oxygen, they have to check the resident's oxygen saturation and if below 92% oxygen saturation, then they would administer the as needed (PRN) oxygen. RN 1 stated the licensed nurse would also consider the resident's diagnosis and not set the oxygen too high and if the resident continues to need the oxygen or have shortness of breath then they would need to complete a change in condition. RN 1 stated licensed nurses are expected to document on the medication administration record (MAR) when they administer a PRN oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/12/2025 at 2:28 p.m. with LVN 2, LVN 2 stated the process for administering PRN oxygen is that she would check the resident's oxygen saturation and if it's below the parameters she would administer the oxygen. LVN 2 stated she would document it on the monitoring form for the vitals. LVN 2 stated oxygen is considered a medication, and she would document it on the MAR. LVN 2 stated every time the resident is being administered oxygen, it should be documented on the MAR. LVN 2 stated if she does not document it, she would not know the resident's trend and miss identifying any changes in the resident's condition such as difficulty in breathing. LVN 2 stated LVN 3 was the assigned LVN part of the morning, and she had to assist and took over LVN 3's assignment including Resident 70. LVN 2 stated it should have been documented on the MAR and she missed it and documented on the vitals, and she meant to document on oxygen. LVN 2 stated it is important that Resident 70 receives oxygen as ordered and make sure proper documentation was completed to monitor the resident. LVN 2 stated after she documents the oxygen administration, she would follow-up 30 minutes (a unit of measurement) to one hour (a unit of measurement) how the resident is tolerating the oxygen documented on the progress notes and why the resident needed it. During an interview on 3/12/2025 at 2:58 p.m. with RN 1, RN 1 stated oxygen is a life-sustaining tool and has to have an order because they are giving something to the resident, and it is considered a treatment. RN 1 stated PRN oxygen is documented on the MAR, if the resident is having SOB. There will be an order to administer the oxygen, and medical staff are to know about the oxygen order. RN 1 stated they would do a change in condition, call the doctor and a family member. RN 1 stated when the licensed nurse does not document and administers the oxygen, they can be given oxygen when it's not really needed. RN 1 stated if they needed and required a change in condition may result not getting treated for the shortness of breath for the actual cause. RN 1 stated it needs to be addressed right away and giving continuous when it's needed. (Please clarify this interview. The sentences are not too clear). During an interview on 3/12/2025 at 2:58 p.m. with RN 1, RN 1 stated oxygen is a life-sustaining tool and has to have an order because they are providing treatment to the resident. RN 1 stated when PRN oxygen is administered the licensed nurse documents it on the MAR. RN 1 stated for Resident 70 the PRN oxygen order parameters is to give oxygen when the resident's oxygen saturation is below 92%. RN 1 stated below 92% oxygen saturation, and the resident is having shortness of breath the licensed nurse should complete a change in condition including calling the doctor and notifying the family. RN 1 stated when the licensed nurses administer the oxygen therapy and does not document in the MAR, the resident could be given oxygen unnecessarily. RN 1 stated when the licensed nurse continues to administer the oxygen therapy to Resident 70 without the required change in condition assessment for shortness of breath then Resident 70 could potentially not get the proper and timely treatment . During a concurrent interview and record review on 3/12/2025 at 3:09 p.m. with RN 1, Resident 70's MAR for 2/2025, 3/2025, and Weights and Vitals Summary from 2/1/2025 to 3/12/2025 were reviewed. RN 1 stated there was no documentation on the MAR that oxygen was administered. RN 1 stated if they documented on the MAR, it means it was administered. RN 1 stated The Weights and Vitals Summary documented the licensed nurse administered the oxygen and indicated the following: On 3/7/2025 at 2:10 a.m., Resident 70's O2 sat 98% oxygen via NC On 3/7/2025 at 2:27 p.m., Resident 70's O2 sat 98% oxygen via NC On 3/8/2025 at 12:36 a.m., Resident 70's O2 sat 96% oxygen via NC (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/8/2025 at 8:30 p.m., Resident 70's O2 sat 97% oxygen via NC On 3/9/2025 at 1:52 a.m., Resident 70's O2 sat 96% oxygen via NC On 3/9/2025 at 12:34 a.m., Resident 70's O2 sat 97% oxygen via NC On 3/10/2025 at 1:06 a.m., Resident 70's O2 sat 96% oxygen via NC On 3/10/2025 at 12:06 p.m., Resident 70's O2 sat 98% oxygen via NC On 3/11/2025 at 12:12 a.m., Resident 70's O2 sat 96% oxygen via NC On 3/11/2025 at 8:54 p.m., Resident 70's O2 sat 97% oxygen via NC On 3/12/2025 at 12:21 a.m., Resident 70's O2 sat 96% oxygen via NC On 3/12/2025 at 11:43 a.m., Resident 70's O2 sat 96% oxygen via NC During an interview on 3/13/2025 at 8:02 a.m. with RN 1, RN 1 stated oxygen is considered medication because it requires a doctor's prescription. During an interview on 3/14/2025 at 2:45 p.m. with the DON, the DON stated PRN oxygen is given when the resident really needs it and if the resident does not need it, they place it in storage. The DON stated if they administer oxygen, they should document it on the MAR. During a review of the facility's P&P titled, Oxygen Administration, last reviewed 9/27/2024, the P&P indicated the purpose of the procedure is to provide guidelines for safe oxygen administration. Verify that there is a physician's order for this procedure. Review the physician's orders. Review the resident's care plan to assess for any special needs of the resident. Before administering oxygen, and while the resident is receiving oxygen therapy. assess for the following: 1. Signs or symptoms of cyanosis (i.e., blue tone to the skin and mucous membranes) 2. Signs or symptoms of hypoxia (i.e., rapid breathing, rapid pulse rate, restlessness, confusion) 3. Signs or symptoms of oxygen toxicity (i.e., tracheal irritation, difficulty breathing, or slow, shallow rate of breathing). 4. Vital signs 5. Lung sounds After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: 1. The date and time that the procedure was performed. 2. The name and title of the individual who performed the procedure. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The rate of oxygen flow, route, and rationale. 4. The frequency and duration of the treatment. 5. The reason for PRN administration. 6. All assessment data obtained before, during, and after the procedure. 7. How the resident tolerated the procedure. 44244 Based on observation, interview, and record review, the facility failed to ensure residents who need respiratory care are provided care consistent with professional standards of practice for three of three sampled residents (Resident 74 and 70) reviewed under the Respiratory care area by failing to: 1. Ensure oxygen (O2) was administered per the physician orders, documented when administered, and monitored while in use for Resident 74. 2. Ensure O2 was administered per the physician orders, documented when administered, and monitored while in use for Resident 70. These deficient practices had the potential to place residents at risk for respiratory distress with a delay in necessary care and treatment. 3. Ensure the oxygen tubing was not touching the floor for Resident 96. The deficient practice had a potential for residents to develop complications such as respiratory infections of using a contaminated oxygen tubing Findings: 1. During a review of Resident 74's Admission Record (AR), the AR indicated the facility admitted the resident on 10/3/2024 and readmitted the resident on 11/25/2024, with diagnoses that included Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), metabolic encephalopathy (an alteration in consciousness due to brain dysfunction), anemia (a condition where the body does not have enough healthy red blood cells), and urinary tract infection (UTI- an infection in the bladder/urinary tract). During a review of Resident 74's History and Physical (H&P), dated 11/26/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 74's Minimum Data Set (MDS - resident assessment tool), dated 1/9/2025, the MDS indicated the resident rarely/never had the ability to understand others and rarely/never had the ability to make herself understood. The MDS further indicated the resident did not experience shortness of breath and did not receive oxygen therapy while a resident in the facility. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 74's Physician Orders, the Physician Orders indicated the following order: - Oxygen, administer O2 at two liters per minute (LPM, a unit of measurement) via nasal cannula (NC, a thin, flexible tube with two prongs that delivers supplemental O2 to a resident's nose). May titrate (adjust) between up to five LMP for O2 saturation (O2 sat- a measurement in percentage [%]) less than 90%, as needed (PRN) for shortness of breath, dated 11/25/2024. During an observation on 3/11/2025 at 11:40 a.m., Resident 74 was observed lying in bed with oxygen infusing at 2 LPM via NC. Resident 74 did not respond to the surveyor. During a concurrent observation and interview on 3/12/2025 at 12:30 p.m., Certified Nursing Assistant (CNA) 5 entered Resident 74's room and stated the resident was being administered O2 at two LPM. CNA 5 stated she often cares for Resident 74 and the resident is always on O2 via NC. CNA 5 stated the licensed nurse knows more about the resident's use of O2. During an interview on 3/12/2025 at 2:23 p.m., with Registered Nurse (RN) 1, RN 1 stated the facility procedure for administering O2 PRN, is to check the resident's O2 saturation and administer O2 as needed. RN 1 stated when a resident requires PRN O2, it is considered a change of condition, and the physician should be notified with the reason why the resident requires the O2. RN 1 stated O2 PRN is documented in the Medication Administration Record (MAR - a record of all medications taken by a resident on a day-to-day basis). During a concurrent interview and record review on 3/12/2025 at 12:30 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 reviewed Resident 74's Physician Orders, Weights and Vitals Summary from 2/2025 to 3/2025, and MAR from 2/2025 to 3/2025. LVN 2 stated she cared for Resident 74 and most days the resident was on O2 via NC. LVN 2 stated Resident 74 had a physician order for O2 PRN because the resident has low O2 saturation and the family requests the O2 for comfort. LVN 2 stated Resident 74 did not have an order for continuous O2 use. LVN 2 stated O2 is considered a medication, and medication should be documented in the MAR. LVN 2 stated she does not document Resident 74's O2 PRN use in the MAR. LVN 2 stated it is important to document PRN O2 administration in the MAR because it is important to document the amount of O2 the resident receives, monitor for the effectiveness of the PRN O2, and document when the O2 was removed after the resident no longer had a need for it. LVN 2 reviewed Resident 74's Weights and Vitals Summary and MAR and noted she administered oxygen to Resident 74, but there was no documented evidence in the MAR indicating the amount of LPM administered, duration of administration, or monitoring for the effectiveness of the PRN administration of oxygen on the following dates and times: - On 2/18/2025 at 11:25 a.m., Resident 74's O2 Sat was 97.0% on Oxygen via NC - On 2/23/2025 at 10:32 a.m., Resident 74's O2 Sat was 96.0% on Oxygen via NC - On 2/26/2025 at 11:27 a.m., Resident 74's O2 Sat was 96.0% on Oxygen via NC - On 3/6/2025 at 11:36 a.m., Resident 74's O2 Sat was 96.0% on Oxygen via NC LVN 2 further stated she did not know why she did not document Resident 74's O2 PRN in the MAR, but she should have. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/12/2025 at 2:58 p.m., with RN 1, RN 1 reviewed Resident 74's Physician Orders, Weights and Vitals Summary from 1/2025 to 3/2025, and MAR from 1/2025 to 3/2025. RN 1 stated it is expected that nurse's document the administration of PRN O2 in the MAR to communicate the resident's need for O2. RN 1 stated if O2 PRN is not documented in the MAR it could potentially result in the resident being administered more oxygen than is needed and could potentially result in the resident not being treated for the underlying cause for the resident's need of the supplemental oxygen. RN 1 reviewed Resident 74's Weights and Vitals Summary and MAR and noted oxygen was documented as administered in the Weights and Vitals Summary, but there was no documented evidence in the MAR indicating the amount of LPM administered, duration of administration, or monitoring for the effectiveness of the PRN administration on the following dates and times: On 1/19/2025 at 8:26 p.m., Resident 74's 02 Sat was 94.0% on Oxygen via NC On 1/20/2025 at 12:03 a.m., Resident 74's O2 Sat was 96.0% on Oxygen via NC On 1/20/2025 at 10:47 p.m., Resident 74's O2 Sat was 96.0% on Oxygen via NC On 1/21/2025 at 1:25 a.m., Resident 74's O2 Sat was 97.0% on Oxygen via NC On 1/21/2025 at 10:18 p.m., Resident 74's O2 Sat was 96.0% on Oxygen via NC On 1/22/202 at 5 1:01 a.m., Resident 74's O2 Sat was 97.0% on Oxygen via NC On 1/23/2025 at 11:10 a.m., Resident 74's O2 Sat was 96.0% on Oxygen via NC On 1/24/2025 at 7:38 p.m., Resident 74's O2 Sat was 95.0% on Oxygen via NC On 1/25/2025 at 8:05 p.m., Resident 74's O2 Sat was 96.0% on Oxygen via NC On 1/28/2025 at 7:50 p.m., Resident 74's O2 Sat was 97.0% on Oxygen via NC On 1/29/2025 at 8:19 p.m., Resident 74's O2 Sat was 96.0% on Oxygen via NC On 1/30/2025 at 11:19 p.m., Resident 74's O2 Sat was 96.0% on Oxygen via NC On 1/31/2025 at 7:40 p.m., Resident 74's O2 Sat was 97.0% on Oxygen via NC On 2/1/2025 at 7:25 p.m., Resident 74's O2 Sat was 95.0% on Oxygen via NC On 2/3/2025 at 8:20 p.m., Resident 74's O2 Sat was 96.0% on Oxygen via NC On 2/4/2025 at 9:43 p.m., Resident 74's O2 Sat was 95.0% on Oxygen via NC On 2/5/2025 at 8:22 p.m., Resident 74's O2 Sat was 96.0% on Oxygen via NC On 2/10/2025 at 10:41 p.m., Resident 74's O2 Sat was 96.0% on Oxygen via NC On 2/11/2025 at 11:13 p.m., Resident 74's O2 Sat was 97.0% on Oxygen via NC (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/12/2025 at 8:18 p.m., Resident 74's O2 Sat was 96.0% on Oxygen via NC On 2/16/2025 at 12:33 a.m., Resident 74's O2 Sat was 98.0% on Oxygen via NC On 2/16/2025 at 8:02 p.m., Resident 74's 02 Sat was 97.0% on Oxygen via NC On 2/17/2025 at 8:46 p.m., Resident 74's 02 Sat was 96.0% on Oxygen via NC On 2/18/2025 at 11:25 a.m., Resident 74's 02 Sat was 97.0% on Oxygen via NC On 2/18/2025 at 8:01 p.m., Resident 74's 02 Sat was 96.0% on Oxygen via NC On 2/19/2025 at 8:16 p.m., Resident 74's 02 Sat was 96.0% on Oxygen via NC On 2/23/2025 at 12:19 a.m., Resident 74's 02 Sat was 96.0% on Oxygen via NC On 2/23/2025 at 10:32 a.m., Resident 74's 02 Sat was 96.0% on Oxygen via NC On 2/26/2025 at 2:41 a.m., Resident 74's 02 Sat was 98.0% on Oxygen via NC On 2/26/2025 at 11:27 a.m., Resident 74's O2 Sat was 96.0% on Oxygen via NC On 2/27/2025 at 8:53 p.m., Resident 74's O2 Sat was 97.0% on Oxygen via NC On 3/2/2025 at 9:54 p.m., Resident 74's O2 Sat was 96.0% on Oxygen via NC On 3/3/2025 at 8:08 p.m., Resident 74's O2 Sat was 97.0% on Oxygen via NC On 3/4/2025 at 12:30 a.m., Resident 74's O2 Sat was 98.0% on Oxygen via NC On 3/4/2025 at 8:24 p.m., Resident 74's O2 Sat was 97.0% on Oxygen via NC On 3/5/2025 at 8:34 p.m., Resident 74's O2 Sat was 97.0% on Oxygen via NC On 3/6/2025 at 11:36 a.m., Resident 74's O2 Sat was 96.0% on Oxygen via NC On 3/7/2025 at 2:50 p.m., Resident 74's O2 Sat was 95.0% on Oxygen via NC On 3/10/2025 at 8:14 p.m., Resident 74's O2 Sat was 97.0% on Oxygen via NC On 3/11/2025 at 12:01 a.m., Resident 74's O2 Sat was 98.0% on Oxygen via NC RN 1 further stated when Resident 74's O2 need and use was not monitored, it could have potentially resulted in an undetected decline in the resident leading to respiratory distress. (continued on next page)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/14/2025 at 9:35 a.m., with the Director of Nursing (DON), the DON reviewed the facility's policy and procedures regarding oxygen administration. The DON stated PRN oxygen is a medication intended for temporary use and is documented in the MAR. The DON stated when a resident has a need for PRN O2, the staff should move the oxygen concentrator (device that delivers supplemental oxygen) from storage to the resident's room, administer the O2 per the PRN order, re-evaluate the resident's temporary need of supplemental O2, and then notify the physician to request to change the order if the resident continues to require the O2 or call 911 if the resident does not recover. The DON stated oxygen should not be administered just because a family requests for it. The DON stated administering unnecessary O2 could potentially result in too much O2 affecting the resident's brain. The DON stated the facility policy was not followed for Resident 74's PRN use of oxygen when oxygen was not administered per the physician's order and was not monitored and documented while in use. During a review of the facility policy and procedures (P&P) titled, Administering Medications, last reviewed 9/27/2024, the P&P indicated medications are administered in a safe and timely manner. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: a. The date and time the medication was administered. b. The dosage. c. The route of administration: d. The injection site (if applicable). e. Any complaints or symptoms for which the drug was administered. f. Any results achieved and when those results were observed; and g. The signature and title of the person administering the drug. If a resident uses PRN medications frequently, the attending physician and interdisciplinary care team, with support from the consultant pharmacist as needed, shall reevaluate the situation, examine the individual as needed, determine if there is a clinical reason for the frequent PRN use, and consider whether a standing dose of medication is clinically indicated. 44376 3. During a review of Resident 96's Admission Record, the Admission Record indicated the facility admitted the resident on 3/6/2024, and readmitted the resident on 2/3/2025, with diagnoses including acute respiratory failure (the lungs are suddenly unable to get enough oxygen into the blood or are struggling to remove carbon dioxide), novel influenza A virus (a new type of flu virus that can infect humans), and pleural effusion (an abnormal buildup of fluid between the lungs and the chest wall, which can make it harder to breathe). (continued on next page)

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Sherman Oaks Health & Rehab	14401 Huston St. Sherman Oaks, CA 91423

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 96's H&P, dated 2/5/2025, the H&P indicated the resident was alert and oriented to person, place, time, and situation. During a review of Resident 96's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had an intact cognition (a person's mental abilities, like thinking, learning, remembering, and understanding, are functioning normally and effectively). The MDS indicated the resident was on oxygen therapy (treatment that provides you with supplemental, or extra, oxygen). During a review of Resident 96's Order Summary Report, dated 3/13/2025, the Order Summary Report indicated an order for: - Administer oxygen (O2) at (2) liters per minute (L/min, the volume of oxygen a patient receives in one minute, measured in liters, and is prescribed by a doctor to meet their individual oxygen needs) via nasal cannula (NC, a device that gives you additional oxygen [supplemental oxygen or oxygen therapy] through your nose). May titrate (adjust) up to (5) L/min for O2 saturation less than (90) %. as needed for Shortness of breath. -Change O2 tubing as needed. During a concurrent observation and interview on 3/12/2025, at 9:55 a.m., with the Assistant Director of Staff Development (ADSD), observed Resident 96's oxygen tubing was touching the floor. The ADSD stated the oxygen tubing should not be touching the floor. The ADSD stated using a contaminated oxygen tubing that has touched the floor can cause respiratory infection to Resident 96. During an interview on 3/13/2025, at 10:09 a.m., with RN 1, RN 1 stated the oxygen tubing of Resident 96 should not be touching the floor. RN 1 stated every time the staff sees an oxygen tubing touching the floor, they should immediately replace them with a new one to prevent respiratory infections on residents. During an interview on 3/14/2025, at 11:37 a.m., with the DON, the DON stated Resident 96's oxygen tubing should not be touching the floor, as soon as the staff sees an oxygen tubing touching the floor they should immediately change them to prevent respiratory infections on residents. The DON stated the staff should use the respiratory receptacle plastic bags to house excess oxygen tubing to prevent them from touching the floor. During a review of the facility's recent P&P titled Infection-Clinical Protocol, last reviewed on 9/27/2024, the P&P indicated the physician or provider, and staff will identify infection transmission risks and (in conjunction with the Infection Preventions) will implement relevant precautions.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 44244 Based on interview and record review, the facility failed to ensure residents who received hemodialysis (HD, process of removing waste products and excess fluid from the body) received treatment consistent with professional standards of practice for one of one sampled resident (Resident 5) reviewed under the Dialysis care area by failing to ensure licensed nurses performed and documented assessments after Resident 5's hemodialysis sessions. This deficient practice placed the resident at risk for a delay in care and services and a delay in detecting complications resulting from HD. Findings: During a review of Resident 5's Admission Record, the Admission Record indicated the facility admitted the resident on 6/14/2023 and readmitted the resident on 7/25/2024 with diagnoses that included end stage renal disease (the kidneys cease functioning on a permanent basis), dependence on renal dialysis, and hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]). During a review of Resident 5's Minimum Data Set (MDS - resident assessment tool) dated 12/22/2024, the MDS indicated the resident was able to understand others and was able to make herself understood. The MDS indicated the resident was dependent on HD. During a review of Resident 5's Order Summary Report, the Order Summary Report indicated a physician's order dated 1/6/2025 for HD at (Dialysis Center [HDC] 1 Address), on Monday/Wednesday/Friday at 12:30 p. m. During a review of Resident 5's Care Plan (CP) regarding hemodialysis, initiated 6/2/2024, the CP indicated to document date, time, and condition of resident post HD. During a review of Resident 5's CP regarding the resident's risk for fluid volume deficit/excess secondary to HD, initiated 6/2/2024, the CP indicated a goal to reduce the risk of complication from fluid volume imbalances. During a review of Resident 5's CP regarding the resident's risk for bleeding from the arteriovenous shunt (surgical connection between the arteries and veins used for HD) site secondary to HD, initiated 6/2/2024, the CP indicated a goal to reduce the risk of bleeding. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/13/2025 at 11:52 a.m. with Minimum Data Set Nurse (MDSN) 1, MDSN 1 reviewed Resident 5's Dialysis Communication Record forms for 2/2025 to 3/2025. MDSN 1 stated Resident 5 has hemodialysis sessions three times a week at HDC 1. MDSN 1 stated when Resident 5 returns from HD, the licensed nurse immediately completes a post HD assessment of the resident to ensure the resident does not have a change of condition like a change in the level of consciousness, bleeding from the AV shunt, or a change in the vital signs. MDSN 1 stated it was important to catch any change of condition quickly and report to the physician because there could be concern that too much fluid was lost during HD. MDSN 1 stated the Dialysis Communication Record form documents that the licensed nurse completed pre and post HD assessments of the resident. MDSN 1 reviewed Resident 5's Dialysis Communication Record form and noted the following: -On 2/5/2025 at 5:15 p.m., there was no documented evidence of a post HD assessment completed for access site location bleeding, breathing patterns/breath sounds, or cognitive status. -on 2/12/2025 at 5:15 p.m., there was no documented evidence of a post HD assessment completed for access site location bleeding. - on 2/19/2025 at 5 p.m., there was no documented evidence a of a post HD assessment completed for access site location bleeding or breathing patterns/breath sounds. - on 2/24/2025 at 5 p.m., there was no documented evidence of a post HD assessment completed for cognitive status. - on 2/26/2025 at 4:50 p.m., there was no documented evidence of a post HD assessment completed for bruit and thrill (sounds heard and vibrations felt to indicate proper functioning of the AV shunt) of the access site. - on 3/3/2025 at 5 p.m., there was no documented evidence of a post HD assessment completed for bruit and thrill of the access site. - on 3/5/2025 at 6:30 p.m., there was no documented evidence of a post HD assessment completed for cognitive status. - on 3/9/2025 at 4:20 p.m., there was no documented evidence of a post HD assessment completed for cognitive status. During an interview on 3/14/2025 at 9:35 a.m. with the Director of Nursing (DON), the DON reviewed the facility policy and procedures (P&P) regarding HD. The DON stated upon return from HD the licensed nurse should assess the residents to ensure the resident is stable. The DON stated it is important that an immediate and complete assessment be done right when the resident returns from HD to catch any changes of condition in a timely way to treat the resident and prevent a further decline. The DON stated staff have in-services every month regarding completing the Dialysis Communication Record, but if an assessment is not documented then it was not done. The DON stated the facility policy was not followed when Resident 5's Dialysis Communication Record forms did not document complete assessments. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility-provided (P&P) titled, End-Stage Renal Disease, Care of Resident with, last reviewed 9/27/2024, the (P&P) indicated residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care. Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. During a review of the facility-provided P&P titled, Care of Resident Receiving Renal Dialysis, last reviewed 9/27/2024, the (P&P) indicated the objective of the policy was to ensure that nursing staff are aware of special needs of residents receiving renal dialysis and provide care accordingly. Complete Dialysis Communication Record during dialysis days and send the form with the resident to be completed by the dialysis nurse. Completed Dialysis Communication Record will be sent back with resident and facility nurse will complete post dialysis. a) Complete pre-dialysis assessment: i. Cognitive status ii. Vital signs iii. Access site (central line, shunt, graft site) iv. Document presence or absence of bruit and/or thrill v. Bleeding at _site_ vi. Breathing patterns / breathing sounds b) Complete post-dialysis assessment on return from treatment. c) Complete additional comments for any significant information. d) Follow up on any dialysis center recommendations. e) Notify MD of any significant change in condition upon return from dialysis center.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 44376 Based on observation, interview, and record review, the facility failed to assess the risk of entrapment (an event in which a resident is caught, trapped, or entangled in spaces in or about the bed rail, mattress, or hospital bed frame) from bed rails (a safety device that's installed along one or both sides of a bed to prevent falls) prior to its continued use to one of 2 sampled residents (Resident 88) reviewed for restraints (are any action or procedure that prevents a person's free body movement to a position of choice and/or normal access to the body by the use of any method, attached or adjacent to a person's body that the person cannot control or remove easily) use by failing to assess the resident for risk of entrapment from bed rails quarterly. The deficient practices predisposed residents to bed entrapment and unnecessary restraints. Findings: During a review of Resident 88's Admission Record, the Admission Record indicated the facility admitted the resident on 2/19/2023, with diagnoses including dementia (a progressive state of decline in mental abilities), age-related physical debility (a state where older adults experience a decline in physical function and become more vulnerable to illness or injury due to weakened muscles, bones, and overall reduced reserve capacity), and history of falling. During a review of Resident 88's History and Physical (H&P), dated 3/5/2025, the H&P indicated the resident was on fall precaution (measures taken to reduce the risk of someone falling and getting hurt) and the resident did not have the capacity to make medical decisions. During a review of Resident 88's Minimum Data Set (MDS, a resident assessment tool), dated 2/23/2025, the MDS indicated the resident usually had the ability to make self-understood and understand others and had impaired cognition (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident required substantial to supervision assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS indicated the resident had a history of fall with no injury. During a review of Resident 88's Order Summary Report, dated 1/7/2025, the Order Summary Report indicated an order for [RESTRAINT] low bed (a bed frame or mattress set that sits closer to the floor than a standard bed, often with a minimalist and modern design, and typically doesn't require a box spring) with bilateral upper siderails/bedrails up with bilateral floor mats (designed to cushion and protect individuals, especially the elderly or those at risk of falls, from injury in the event of a fall or roll out of bed) to decrease potential injury due to unpredictable movement related to dementia. Every shift. During a review of Resident 88's Fall Risk Assessment, dated 2/22/2025, the Fall Risk Assessment indicated the resident was high risk for falls. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 88's Side Rail Safety/Entrapment Assessment, the Side Rail Safety/Entrapment Assessment was last done on 2/21/2023. During a review of Resident 88's Care Plan (CP) titled Low bed with bilateral upper side rails up with bilateral floor mats to decrease potential injury due to unpredictable movement related to dementia, last revised on 3/16/2023, the CP indicated an intervention of quarterly assessment and follow up by interdisciplinary team (a group of healthcare professionals [like nurses, therapists, social workers, etc.] who work together to provide comprehensive care, focusing on the individual needs of each resident and using their combined expertise to create a holistic plan of care) to ensure appropriateness of restraint. During a concurrent observation, interview, and record review on 3/13/2025, at 10:54 a.m., with Registered Nurse (RN) 1, inside Resident 88's room, observed Resident 88 had bilateral upper side rails up, on a low bed with bilateral floor mats. Reviewed Resident 88's Order Summary Report, Side Rail Safety/Entrapment Assessment, and Care Plans. RN 1 stated the last Side Rail Safety/Entrapment Assessment for Resident 88 was done on 2/21/2023. RN 1 stated Side Rail Safety/Entrapment Assessment should be done quarterly for Resident 88 to evaluate its appropriateness and safe use, and to decrease restraint use. RN 1 stated the failure of the licensed staff to perform Side Rail Safety/Entrapment Assessment can result to Resident 88 agitation, contracture (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff), and further decline in mobility. During an interview on 3/14/2025, at 11:37 a.m., with the Director of Nursing (DON), inside the facility's conference room, the DON stated the licensed staff should have done a Side Rail Safety/Entrapment Assessment quarterly on Resident 88 to ensure its appropriate use and to prevent accidents such as entrapment. The DON stated before they place a resident on a restraint side rail, they need a physician's order, assessment for safety/entrapment, informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) from the resident or representative, and a care plan to ensure its safe use. During a review of the facility's recent policy and procedure (P&P) titled Resident Assessments, last reviewed on 9/27/2024, the P&P indicated a comprehensive assessment of every resident's need is made at intervals designated by OBRA and PPS requirements. The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews according to the following requirements: (1) Admission Assessment (Comprehensive); (2) Quarterly Assessment; (3) Annual Assessment (Comprehensive); (4) Significant Change in Status Assessment (SCSA) (Comprehensive). (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's recent P&P titled Bed Safety and Bed Rails, last reviewed on 9/27/2024, the P&P indicated bed rails are adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one-eight lengths. Some bed rails are not designed as part of the bed by the manufacturing and may be installed on or used along the side of a bed. For purpose of this policy bed rails include: a. side rails; b. safety rails; and c. grab/assist bars. The resident assessment to determine risk of entrapment includes but not limited to: a. medical diagnosis, condition, symptoms, and/or behavioral symptoms; b size and weight; c. sleep habits; d. medication(s) e. acute medical or surgical interventions; f. underlying medical conditions; g. existence of delirium; h. ability to toilet self safely; i. cognition; j. communication; k. mobility (in and out of bed); and l. risk of falling.

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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** 43455 Based on observation, interview, and record review, the facility failed to account for three (3) doses of Controlled Medication (also known as Controlled Drug and Controlled Substance [CM, CD, CS]- medications which have a potential for abuse and may also lead to physical or psychological dependence) for Residents 5, 97 and 272 in one (1) of four (4) inspected medication carts (Medication Cart Middle Station Morning.) As a result, control and accountability of CMs and availability of medications did not follow state and federal regulations and facility policy and procedures (P&P). These deficient practices increased the opportunity for CM diversion (the transfer of a controlled medication or other medication from a lawful to an unlawful channel of distribution or use) and the risk that Residents 5, 97 and 272 could have accidental exposure to harmful medications possibly leading to physical and psychosocial harm and hospitalization . Findings: During a concurrent observation and interview on 3/12/2025 at 11:45 a.m., with Licensed Vocational Nurse (LVN) 3, of Medication Cart Middle Station Morning, there was a discrepancy in the count between the Antibiotic or Controlled Drug Record accountability log and the amount of medication remaining in the medication cart or medication bubble pack (medication packaging system that contains individual doses of medication per bubble) for the following residents: 1. One dose of Belbuca (a CM used to relieve pain) 150 milligram ([mg] - a unit of measure of mass) film (type of medication delivery system) was missing from the medication cart compared to the count indicated on the Antibiotic or Controlled Drug Record accountability log for Resident 5. The Antibiotic or Controlled Drug Record accountability log for Belbuca indicated the medication cart should have contained a total of 30 Belbuca 150 mg films, after the last administration of Belbuca 150 mg film documented/signed-off on 3/11/2025 at 8 p.m.; however, the medication cart contained 29 Belbuca 150 mg tablets and no other documentation of subsequent administrations. 2. One dose of hydrocodone with acetaminophen (a CM used to relieve pain) 5-325 mg tablet was missing from the medication bubble pack compared to the count indicated on the Antibiotic or Controlled Drug Record accountability log for Resident 97. The Antibiotic or Controlled Drug Record accountability log for hydrocodone with acetaminophen indicated the medication bubble pack should have contained a total of 9 hydrocodone with acetaminophen 5-325 mg tablets, after the last administration of hydrocodone with acetaminophen 5-325 mg tablet documented/signed-off on 3/11/2025 at 9 a.m., however the medication bubble pack contained 8 hydrocodone with acetaminophen 5-325 mg tablets and no other documentation of subsequent administrations. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. One dose of pregabalin (a CM used for neuropathy [nerve damage that can cause pain, numbness, tingling, or weakness]) 75 mg capsule was missing from the medication bubble pack compared to the count indicated on the Antibiotic or Controlled Drug Record accountability log for Resident 272. The Antibiotic or Controlled Drug Record accountability log for pregabalin indicated the medication bubble pack should have contained a total of 26 pregabalin 75 mg capsules, after the last administration of pregabalin 75 mg tablet documented/signed-off on 3/11/2025 at 9 a.m.; however, the medication bubble pack contained 25 pregabalin 75 mg capsules and no other documentation of subsequent administrations. LVN 3 stated she administered Belbuca 150 mg film to Resident 5, hydrocodone with acetaminophen 5-325 mg tablet to Resident 97, and pregabalin 75 mg capsule to Resident 272 that morning (3/12/2025) and forgot to sign the Antibiotic or Controlled Drug Record accountability logs. LVN 3 stated she failed to follow the facility's P&P of signing each CM dose on the Antibiotic or Controlled Drug Record accountability log after preparing the dose for the residents. LVN 3 stated she understood it was important to sign each dose once administered to ensure accountability, prevention of CM diversion, and accidental exposures of harmful substances to residents. LVN 3 stated if documentation was not accurate then it can lead to medication error if overdosed (administering more than the prescribed dose) leading to stoppage of breathing, hospitalization , and possibly death for Residents 5, 97, and 272. During an interview on 3/13/2025 at 10:41 a.m., with the Director of Nursing (DON,) the DON stated LVN 3 failed to follow facility P&P of documenting the preparation of CM immediately on the Antibiotic or Controlled Drug Record accountability log for Residents 5, 97 and 272. The DON stated not documenting the Antibiotic or Controlled Drug Record timely can lead to accountability failures, CM diversion, inaccurate clinical records, and accidental use and overdose of harmful substances for residents. During a review of Resident 5's Admission Record (a document containing demographic and diagnostic information,) dated 3/12/2025, the Admission Record indicated Resident 5 was originally admitted to the facility on [DATE] and readmitted the resident on 7/25/2024 with diagnoses including chronic pain. During a review of Resident 5's Order Summary Report, dated 3/12/2025, the Order Summary Report indicated Resident 5 was prescribed Belbuca 150 mg film to place and dissolve one (1) strip (film) buccally (in the cheek) three (3) times a day for chronic pain, starting 8/24/2024. During a review of Resident 5's Medication Administration Record ([MAR] - a record of mediations administered to residents), for 3/2025, the MAR indicated Resident 5 was prescribed Belbuca 150 mg film to place and dissolve one (1) strip buccally three (3) times a day for chronic pain, to be given at 10 a.m. 2 p.m., and 8 p.m., and was administered a dose on 3/12/2025 at 10 a.m. During a review of Resident 97's Admission Record dated 3/12/2025, the Admission Record indicated Resident 97 was originally admitted to the facility on [DATE] with a diagnosis including pressure ulcers stage 4 (wound that penetrates all 3 layers of the skin) and intravertebral disc degeneration lumbar region with discogenic back pain (breakdown of the spinal discs, causing pain and discomfort.) (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 97's Order Summary Report, dated 3/12/2025, the Order Summary Report indicated Resident 97 was prescribed hydrocodone with acetaminophen 5-325 mg tablet to give one (1) tablet by mouth once a day 30 to 60 minutes prior to wound care, starting 8/30/2024. During a review of Resident 97's MAR for 3/2025, the MAR indicated Resident 97 was prescribed hydrocodone with acetaminophen 5-325 mg tablet to give one (1) tablet by mouth once a day 30 to 60 minutes prior to wound care at 9 a.m., and was administered a dose on 3/12/2025 at 9 a.m. During a review of Resident 272's Admission Record dated 3/12/2025, the Admission Record indicated Resident 272 was originally admitted to the facility on [DATE] with diagnoses including neuropathy. During a review of Resident 272's Order Summary Report dated 2/25/2025, the Order Summary Report indicated Resident 272 was prescribed pregabalin 75 mg capsule to give by mouth twice a day for neuropathy, starting 3/4/2025. During a review of Resident 272's MAR for 3/2025, the MAR indicated Resident 272 was prescribed pregabalin 75 mg twice a day for neuropathy to be given at 9 a.m. and 5 p.m., and was administered a dose on 3/12/2025 at 9 a.m. During a review of the P&P titled Controlled Medication Storage, last reviewed 1/15/2025, the P&P indicated that At each shift change, a physical inventory of all Schedule II ., is conducted by two licensed nurses .and is documented on the CS accountability record During a review of the P&P titled Controlled Medications, last reviewed 9/27/2024, the P&P indicated: Medications included in the Drug Enforcement Administration classification as CS are subject to special handling, storage, disposal, and recordkeeping at the facility, in accordance with federal and state laws and regulations. A. The DON and the Consultant Pharmacist maintain the facility's compliance with federal and state laws and regulations in the handling of CMs. C. When a CM is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the MAR: 1. Date and time of administration 2. Amount administered 3. Signature of the nurse administering the dose on the accountability record at the time the medication is removed from the supply.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on interview and record review, the Consultant Pharmacist (CP) failed to report any irregularities in the monthly drug regimen review to the attending physician and director of nursing to two (2) of three (3) sampled residents (Resident 42 and 79) reviewed for unnecessary medication (Resident 42 and 79) use by failing to: 1. Ensure Resident 42 had monitoring for signs and symptoms of bleeding with the use of clopidogrel (a medication used for paroxysmal atrial fibrillation [irregular and fast heartbeat] that thins the blood) and Eliquis (a medication used for atrial fibrillation that thins the blood) 2. Ensure Resident 42 had monitoring for signs and symptoms of drug toxicity (accumulation of an excessive amount of any medication in the bloodstream) with the use of gabapentin (a medication used for epilepsy [seizure - bursts of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle movements, behaviors, sensations or states of awareness]) 3. Ensure Resident 79 had monitoring for lipid panel (blood test that measures levels of fats [lipids], including cholesterol and triglycerides, to assess risk of heart disease) with the use of atorvastatin (a medication used for hyperlipidemia (having high lipid levels in the blood.) These deficient practices had the potential to cause adverse consequences (also known as side effects - undesired, unwanted, unwanted, or dangerous effects that a drug may have, such as bleeding, bruising, blurred visions, nausea, vomiting, chest pain, shortness of breath) to Residents 42 and 79 from the continued use of these medications. Cross Reference F656, F757 Findings: a. During a review of Resident 42's Admission Record (a document containing demographic and diagnostic information,) dated 3/13/2025, the Admission Record indicated the facility originally admitted Resident 42 to the facility on [DATE] and readmitted the resident on 4/20/2024 with a diagnoses including epilepsy and paroxysmal atrial fibrillation. During a review of Resident 42's Order Summary Report, dated 3/13/2025, the Order Summary Report indicated Resident 42 was prescribed the following: 1. Eliquis 5 mg to give one (1) tablet by mouth once a day for atrial fibrillation, starting 4/25/2024 2. Clopidogrel 75 mg to give one (1) tablet by mouth once a day for paroxysmal atrial fibrillation, starting 8/2/2024 3. Gabapentin 600 mg to give one (1) tablet by mouth three (3) times a day for epilepsy, starting 4/29/2024 (continued on next page)

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 42's Care Plan (a document outlining a detailed approach to care customized to an individual resident's need), initiated 4/20/2024, the Care Plan indicated resident: 1. At risk for bleeding and bruising due to anticoagulant (blood thinner) therapy Eliquis. Risk factors: Abnormal bleeding. Easy skin bruising or discolorations. Goal: no unrecognized sign and symptoms of bleeding .daily. Assess for signs and symptoms of bleeding. Assess for other possible causes of bruising. 2. Am at risk for injury, ineffective breathing pattern, confusion, and disorientation because of seizure activity. I am at risk for potential drug toxicity related to my use of gabapentin. My risk of complications and injury will be minimized through appropriate interventions. Observe for signs and symptoms of drug toxicity such as nausea, vomiting, dizziness, severe drowsiness, blurred visions, double vision, altered level of consciousness, chest pain and shortness of breath and notify medical doctor. Staff will assess for febrile reactions (these may precipitate seizures.) Staff will assess for potential side effects of medication and will notify my physician as needed. During a review of Resident 42's (Medication Administration Record ([MAR] - a record of medication administrations and medication related monitoring), for 3/2025, the MAR indicated Resident 42 was prescribed the following: 1. Eliquis 5 mg one (1) tablet by mouth once a day for atrial fibrillation to be given at 9 a.m. 2. Clopidogrel 75 mg one (1) tablet by mouth twice a day for paroxysmal atrial fibrillation to be given at 9 a.m. and 5 p.m. 3. Gabapentin 600 mg one (1) tablet by mouth three (3) times a day for epilepsy to be given at 9 a.m., 1 p.m. and 5 p.m. The MAR did not contain documentation for monitoring for signs and symptoms of bleeding and bruising with the use of clopidogrel and Eliquis, and did not contain monitoring for signs and symptoms of drug toxicity with the use of gabapentin. b. During a review of Resident 79's Admission Record dated 3/14/2025, the Admission Record indicated the facility originally admitted Resident 79 to the facility on [DATE] and readmitted the resident on 09/17/2024 with a diagnosis including hyperlipidemia. During a review of Resident 79's Order Summary Report, dated 3/12/2025, the Order Summary Report indicated Resident 79 was prescribed atorvastatin 20 mg give one (1) tablet by mouth at bedtime for hyperlipidemia, starting 9/17/2024. During a review of Resident 79's MAR for 3/2025, the MAR indicated Resident 79 was prescribed atorvastatin 20 mg one (1) tablet by mouth at bedtime for hyperlipidemia, to be given at 9 p.m. During a review of Resident 79's Care Plan initiated 9/18/2024, the Care Plan indicated resident: Is at risk for cardiac distress related to . hyperlipidemia (HLD). Goal - will have no unrecognized signs and symptoms of cardiac distress daily until the next assessment. Monitor effect of medication. Inform medical doctor if ineffective. Laboratory work as ordered. Inform Medical doctor of result promptly. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 79's clinical chart on 3/12/2025 at 1:48 p.m., the clinical chart did not contain an order to obtain a lipid panel since admission, and the clinical chart did not contain any lipid laboratory results prior to admission. During a concurrent record review and interview on 3/13/2025 at 10:41 a.m., with the Director of Nursing (DON,) the DON reviewed Resident 42's Care Plan dated 4/20/2024 and MAR for 3/2025. The DON stated Resident 42's Care Plan dated 4/20/2024 indicated Resident 42 was at risk of bleeding and bruising and to assess for signs and symptoms of bleeding and bruising related to blood thinner use and was at risk for potential drug toxicity and to observe for signs and symptoms of drug toxicity related to gabapentin use. The DON stated monitoring for bleeding and bruising and signs and symptoms of drug toxicity would be documented on the MAR, and that the DON was unable to locate documentation for monitoring for bleeding and bruising related to use of clopidogrel and Eliquis and sign and symptoms of drug toxicity related to use of gabapentin for Resident 42 on the 3/2025 MAR. The DON stated that monitoring for bleeding and bruising with clopidogrel and Eliquis use was important to ensure Resident 42 does not have bleeding that was unnoticed, which may harm the resident leading to hospitalization and death, and monitoring for drug toxicity with gabapentin use was important to minimize the side effects of gabapentin and prevent harm such as chest pain and shortness of breath to Resident 42. The DON stated the facility failed to implement the Care Plan to accurately reflect the needs of Resident 42 and ensure to maintain the highest level of functionality and quality of life, with adequate (acceptable) side effect monitoring with the use of clopidogrel, Eliquis and gabapentin. The DON stated that monitoring signs and symptoms of side effects related to Eliquis, clopidogrel, and gabapentin will be immediately implemented for Resident 42. The DON stated monitoring for bleeding with blood thinner use was considered standard of practice. During the same concurrent record review and interview on 3/13/2025 at 10:41 a.m., with the DON, the DON reviewed Resident 79's clinical chart, Care Plan dated 9/18/2024 and MAR for 3/2025. The DON stated Resident 79's Care Plan dated 9/18/2024 indicated Resident 79 was at risk of Is at risk for cardiac distress related to hyperlipidemia, to monitor effect of medication and laboratory work. The DON stated the DON was unable to locate any laboratory results for lipid panel prior to and since admission to the facility. The DON stated it was important to check for lipid levels for residents using atorvastatin to know if the medications was effective, and not causing more harm than benefit. The DON stated the facility failed to implement the Care Plan to accurately reflect the needs of Resident 79 and ensure to maintain the highest level of functionality and quality of life, with adequate monitoring for lipid levels with the use of atorvastatin. The DON stated that lipid panel will be immediately ordered for Resident 79. The DON stated lipid panel monitoring was considered standard of practice. (continued on next page)

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 3/18/2025 at 1:48 p.m., with the CP, the CP stated Resident 42 should be monitored for the side effects of bleeding and bruising with the use of clopidogrel and Eliquis. The CP stated the concern with lack of monitoring for the side effects of clopidogrel and Eliquis may result in harming Resident 42 by causing bleeding that may go unnoticed. The CP stated Resident 79 should be monitored for lipid levels at least once at admission and possibly once a year to ensure the atorvastatin was effective in lowering the lipid levels and if any changes to the dose or the medication was necessary. The CP stated the CP reviewed and completed Resident 42's and 79's drug regimen review for December 2025, January 2025 and February 2025 and failed to identify lack of monitoring for bleeding and bruising for clopidogrel and Eliquis, and lack of monitoring for side effects of gabapentin for Resident 42, and failed to identify lack of lipid panel monitoring for Resident 79 in the monthly written reports to the facility. The CP stated these monitoring was considered standard of practice and without adequate monitoring these medications have the potential to be used unnecessarily causing more harm than benefit to Resident 42 and 79. During a review of facility policy & procedures (P&P) titled Anticoagulation - Clinical Protocol, last reviewed 9/27/2024, the policy indicated: 1. As part of the initial assessment, the physician and staff will identify individuals who are currently anticoagulated: for example, those with recent history of .atrial fibrillation. a. Assess for any signs or symptoms related to adverse drug reactions due to the medication alone or in combination with other medications. 5. The staff and physician will monitor for possible complications in individuals who are being anticoagulated . During a review of facility P&P titled Medication Regimen Review, last reviewed 9/27/2024, the P&P indicated The CP performs a comprehensive medication regimen review at least monthly. The Medication Regimen Review includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy. Findings and recommendations are reported to the DON and the attending physician, and if appropriate, the medical director and/or the administrator. D. Resident-specific irregularities and/or clinically significant risks resulting from or associated with medications are documented and reported to the DON, and/or prescriber as appropriate. During a review of the facility's P&P, titled Adverse consequences and Medication Errors, last reviewed 9/27/2024, the P&P indicated: 1. Residents receiving any medication that has a potential for an adverse consequence will be monitored to ensure that any such consequences are promptly identified and reported. 2. An 'adverse consequence' is defined as an unpleasant symptom or event that is due to or associated with a medication, such as an impairment or decline in an individual's mental or physical condition or functional or psychosocial status. An adverse consequence may include: a. Adverse drug/medication reaction (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Side effect 4. The staff and practitioner shall strive to minimize adverse consequences by: a. Following relevant clinical guidelines and manufacturer's specifications for use, dose, administration, duration, and monitoring of the medication. During a review of facility P&P titled Lab and Diagnostic Test Results - Clinical Protocol, last reviewed 9/27/2024, the policy indicated: 1. The physician will identify, and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs.

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on interview and record review, the facility failed to ensure that resident's drug regimen was free from unnecessary drugs (any drug in excess) for three (3) of three (3) sampled residents (Resident 42, 79, and 40) for unnecessary medication review by failing to: 1. Monitor the side effects (also known as adverse consequences - unwanted, uncomfortable, or dangerous effects that a drug may have) of clopidogrel (a medication used for paroxysmal atrial fibrillation [irregular and fast heartbeat] that thins the blood) and Eliquis (a medication used for atrial fibrillation that thins the blood) for Resident 42. As a result, Resident 42 did not have monitoring for sign and symptoms of bleeding for the use of clopidogrel and Eliquis between 3/1/2025 and 3/13/2025. 2. Monitor the side effects of gabapentin (a medication used for epilepsy [seizure - bursts of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle movements, behaviors, sensations or states of awareness]) for Resident 42. As a result, Resident 42 did not have monitoring for signs and symptoms of drug toxicity (accumulation of an excessive amount of any medication in the bloodstream) with the use of gabapentin between 3/1/2025 and 3/13/2025. 3. Monitor a lipid panel (blood test that measures levels of fats [lipids], including cholesterol and triglycerides, to assess risk of heart disease) for Resident 79 with the use of atorvastatin (a medication used for hyperlipidemia (having high lipid levels in the blood) since 9/17/2024. 4. Monitor the side effects (an often harmful and unwanted effect) of apixaban (a blood thinner that treats and helps prevent blood clots that are related to certain conditions involving the heart and blood vessels) for Resident 40. These deficient practices had the potential to cause Residents 42, 79, and 40 to receive suboptimal (less than the highest standard or quality) care leading to the use of unnecessary medications causing potential side effects and negatively impacting their physical, mental, and psychosocial well-being. Cross reference with F656, F756 Findings: 1&2. During a review of Resident 42's Admission Record (a document containing demographic and diagnostic information,) dated 3/13/2025, the Admission Record indicated the facility originally admitted Resident 42 to the facility on [DATE] and readmitted the resident on 4/20/2024 with diagnoses including epilepsy and paroxysmal atrial fibrillation. During a review of Resident 42's Order Summary Report, dated 3/13/2025, the Order Summary Report indicated Resident 42 was prescribed the following: 1. Eliquis 5 mg to give one (1) tablet by mouth once a day for atrial fibrillation, starting 4/25/2024 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. clopidogrel 75 mg to give one (1) tablet by mouth once a day for paroxysmal atrial fibrillation, starting 8/2/2024 3. gabapentin 600 mg to give one (1) tablet by mouth three (3) times a day for epilepsy, starting 4/29/2024 During a review of Resident 42's Care Plan (a document outlining a detailed approach to care customized to an individual resident's need), initiated 4/20/2024, the Care Plan indicated resident: 1. At risk for bleeding and bruising due to anticoagulant (blood thinner) therapy Eliquis. Risk factors: Abnormal bleeding. Easy skin bruising or discolorations. Goal: no unrecognized sign and symptoms of bleeding .daily. Assess for signs and symptoms of bleeding. Assess for other possible causes of bruising. 2. Am at risk for injury, ineffective breathing pattern, confusion, and disorientation because of seizure activity. I am at risk for potential drug toxicity related to my use of gabapentin. My risk of complications and injury will be minimized through appropriate interventions. Observe for signs and symptoms of drug toxicity such as nausea, vomiting, dizziness, severe drowsiness, blurred visions, double vision, altered level of consciousness, chest pain and shortness of breath and notify medical doctor. Staff will assess for febrile reactions (these may precipitate seizures.) Staff will assess for potential side effects of medication and will notify my physician as needed. During a review of Resident 42's (Medication Administration Record ([MAR] - a record of medication administrations and medication related monitoring), for 3/2025, the MAR indicated Resident 42 was prescribed the following: 1. Eliquis 5 mg one (1) tablet by mouth once a day for atrial fibrillation to be given at 9 a.m. 2. clopidogrel 75 mg one (1) tablet by mouth twice a day for paroxysmal atrial fibrillation to be given at 9 a.m. and 5 p.m. 3. gabapentin 600 mg one (1) tablet by mouth three (3) times a day for epilepsy to be given at 9 a.m., 1 p.m. and 5 p.m. The MAR did not contain documentation for monitoring for signs and symptoms of bleeding and bruising with the use of clopidogrel and Eliquis, and did not contain monitoring for signs and symptoms of drug toxicity with the use of gabapentin. 3. During a review of Resident 79's Admission Record dated 3/14/2025, the Admission Record indicated the facility originally admitted Resident 79 to the facility on [DATE] and readmitted the resident on 09/17/2024 with diagnoses including hyperlipidemia. During a review of Resident 79's Order Summary Report, dated 3/12/2025, the Order Summary Report indicated Resident 79 was prescribed atorvastatin 20 mg give one (1) tablet by mouth at bedtime for hyperlipidemia, starting 9/17/2024. During a review of Resident 79's MAR for 3/2025, the MAR indicated Resident 79 was prescribed atorvastatin 20 mg one (1) tablet by mouth at bedtime for hyperlipidemia, to be given at 9 p.m. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 79's Care Plan initiated 9/18/2024, the Care Plan indicated resident: Is at risk for cardiac distress related to . hyperlipidemia (HLD). Goal - will have no unrecognized signs and symptoms of cardiac distress daily until the next assessment. Monitor effect of medication. Inform medical doctor if ineffective. Laboratory work as ordered. Inform Medical doctor of result promptly. During a review of Resident 79's clinical chart on 3/12/2025 at 1:48 p.m., the clinical chart did not contain an order to obtain a lipid panel since admission, and the clinical chart did not contain any lipid laboratory results prior to admission. During an interview on 3/12/2025 at 2:40 p.m. with Licensed Vocational Nurse (1,) LVN 1 stated Resident 79 should be monitored for lipid levels at least once to ensure the atorvastatin was effective in lowering the lipid levels and if any changes to the dose or the medication was necessary. During a concurrent record review and interview on 3/13/2025 at 10:41 a.m., with the Director of Nursing (DON,) the DON reviewed Resident 42's Care Plan dated 4/20/2024 and March 2025 MAR. The DON stated Resident 42's Care Plan dated 4/20/2024 indicated Resident 42 was at risk of bleeding and bruising and to assess for signs and symptoms of bleeding and bruising related to blood thinner use, and was at risk for potential drug toxicity and to observe for signs and symptoms of drug toxicity related to gabapentin use. The DON stated monitoring for bleeding and bruising and signs and symptoms of drug toxicity would be documented on the MAR, and that the DON was unable to locate documentation for monitoring for bleeding and bruising related to use of clopidogrel and Eliquis and sign and symptoms of drug toxicity related to use of gabapentin for Resident 42 on the March 2025 MAR. The DON stated that monitoring for bleeding and bruising with clopidogrel and Eliquis use was important to ensure Resident 42 does not have bleeding that was unnoticed, which may harm the resident leading to hospitalization and death, and monitoring for drug toxicity with gabapentin use was important to minimize the side effects of gabapentin and prevent harm such as chest pain and shortness of breath to Resident 42. The DON stated the facility failed to implement the Care Plan to accurately reflect the needs of Resident 42 and ensure to maintain the highest level of functionality and quality of life, with adequate (acceptable) side effect monitoring with the use of clopidogrel, Eliquis and gabapentin. The DON stated that monitoring signs and symptoms of side effects related to Eliquis, clopidogrel and gabapentin will be immediately implemented for Resident 42. The DON stated monitoring for bleeding with blood thinner use was considered standard of practice. During the same concurrent record review and interview on 3/13/2025 at 10:41 a.m., with the DON, the DON reviewed Resident 79's clinical chart, Care Plan dated 9/18/2024 and MAR for 3/2025. The DON stated Resident 79's Care Plan dated 9/18/2024 indicated Resident 79 was at risk of for cardiac distress related to hyperlipidemia, and to monitor effect of medication and laboratory work. The DON stated she was unable to locate any laboratory results for lipid panel prior to and since admission to the facility. The DON stated it was important to check for lipid levels for residents using atorvastatin to know if the medications was effective, and not causing more harm than benefit. The DON stated the facility failed to implement the Care Plan to accurately reflect the needs of Resident 79 and ensure to maintain the highest level of functionality and quality of life, with adequate monitoring for lipid levels with the use of atorvastatin. The DON stated that lipid panel will be immediately ordered for Resident 79. The DON stated lipid panel monitoring was considered standard of practice. (continued on next page)

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 3/18/2025 at 1:48 p.m., with the Consultant Pharmacist (CP,) the CP stated Resident 42 should be monitored for the side effects of bleeding and bruising with the use of clopidogrel and Eliquis. The CP stated the concern with lack of monitoring for the side effects of clopidogrel and Eliquis may result in harming Resident 42 by causing bleeding that may go unnoticed. The CP stated Resident 79 should be monitored for lipid levels at least once at admission and possibly once a year to ensure the atorvastatin was effective in lowering the lipid levels and if any changes to the dose or the medication was necessary. The CP stated the CP reviewed and completed Resident 42's and 79's drug regimen review for December 2025, January 2025 and February 2025 and failed to identify lack of monitoring for bleeding and bruising for clopidogrel and Eliquis, and lack of monitoring for side effects of gabapentin for Resident 42, and failed to identify lack of lipid panel monitoring for Resident 79 in the monthly written reports to the facility. The CP stated these monitoring was considered standard of practice and without adequate monitoring these medications have the potential to be used unnecessarily causing more harm than benefit to Resident 42 and 79. During a review of the facility's policy & procedures (P&P) titled Care Plan Comprehensive, last reviewed 9/27/2024, the P&P indicated that A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's medical, physical, mental and psychosocial needs is developed and implemented for each resident. 7. The comprehensive person-centered care plan: b. Describes the services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being. e. reflects currently recognized standards of practice for problem areas and conditions. During a review of the facility's P&P titled Anticoagulation - Clinical Protocol, last reviewed 9/27/2024, the policy indicated: 1. As part of the initial assessment, the physician and staff will identify individuals who are currently anticoagulated: for example, those with recent history of .atrial fibrillation. a. Assess for any signs or symptoms related to adverse drug reactions due to the medication alone or in combination with other medications. 5. The staff and physician will monitor for possible complications in individuals who are being anticoagulated . During a review of the facility's P&P titled Medication Regimen Review, last reviewed 9/27/2024, the policy indicated The CP performs a comprehensive medication regimen review at least monthly. The Medication Regimen Review includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy. During a review of the facility's P&P, titled Adverse consequences and Medication Errors, last reviewed 9/27/2024, the P&P indicated: (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Residents receiving any medication that has a potential for an adverse consequence will be monitored to ensure that any such consequences are promptly identified and reported. 2. An 'adverse consequence' is defined as an unpleasant symptom or event that is due to or associated with a medication, such as an impairment or decline in an individual's mental or physical condition or functional or psychosocial status. An adverse consequence may include: a. Adverse drug/medication reaction b. Side effect 4. The staff and practitioner shall strive to minimize adverse consequences by: a. Following relevant clinical guidelines and manufacturer's specifications for use, dose, administration, duration, and monitoring of the medication. During a review of facility P&P titled Lab and Diagnostic Test Results - Clinical Protocol, last reviewed 9/27/2024, the policy indicated: 5. The physician will identify, and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. 44376 4. During a review of Resident 40's Admission Record, the Admission Record indicated the facility admitted the resident on 6/28/2017, and readmitted the resident on 2/11/2024, with diagnoses including history of venous thrombosis (when the blood clot blocks a vein) and embolism (a blockage in a blood vessel caused by something traveling through the bloodstream and getting stuck, like a clot or air bubble), long-term use of anticoagulants, and atherosclerotic heart disease (the buildup of fats, cholesterol and other substances in and on the artery walls). During a review of Resident 40's History and Physical (H&P), dated 2/24/2025, the H&P indicated the resident did not have a capacity to make medical decision. During a review of Resident 40's Minimum Data Set (MDS, a resident assessment tool), dated 1/6/2025, the MDS indicated the resident sometimes had the ability to make self-understood and understand others and had impaired cognition (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident was on a high-risk drug class anticoagulant. During a review of Resident 40's Order Summary Report, printed on 3/14/2025, the Order Summary Report indicated a physician's order for apixaban oral tablet 5 milligrams (mg, a unit of weight). Give 1 tablet by mouth two times a day for deep vein thrombosis prophylaxis (DVT PPX, taking steps to prevent blood clots from forming in the deep veins of the legs) on 2/14/2024; however, there was no order for monitoring for its adverse effects (unwanted or harmful outcomes that can happen as a result of treatment, such as medication or surgery, ranging from mild to severe). (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 40's Care Plan (CP) titled Apixaban. At risk for adverse effect from black box medication (the Food and Drug Administration's [FDA, a US government agency that makes sure our food, medicines, medical devices, and other products are safe and effective] strongest warning, indicating a serious risk of side effects, potentially life-threatening, that healthcare providers and patients should be aware of, initiated on 2/25/2024, the CP indicated an intervention to monitor for potential risk, effects and alert MD when indicated. During a concurrent interview and record review on 3/13/2025, at 11:06 a.m., with Registered Nurse (RN) 1, reviewed Resident 40's Order Summary Report, Medication Administration Report, and Care Plans. RN 1 stated there was no order for monitoring for adverse effect on the use of Apixaban on Resident 40. RN 1 stated the medication was ordered since 2/14/2024, and for one year there was no monitoring for adverse effect of its use. RN 1 stated it was important to monitor for adverse effect of taking Apixaban to monitor from bleeding to report to the physician to prevent further complications. During an interview on 3/14/2025, at 11:37 a.m., with the Director of Nursing (DON), the DON stated the staff should have monitored for the adverse effect of Resident 40's use of Apixaban. The DON stated the staff should have obtained an order to monitor for its adverse effect from the physician as soon as they noticed it was lacking. The DON stated it was important to monitor for the adverse effect on the use of apixaban on Resident 40 to ensure the resident was not bleeding and for safety. During a review of the facility's recent P&P titled Anticoagulation- Clinical Protocol, last reviewed on 9/27/2024, the P&P indicated to assess for signs and symptoms related to adverse drug reactions due to the medication alone or in combination with other medications. Assess for evidence of effects related to subtherapeutic or greater than therapeutic drug level related to that particular drug (for example, a resident with an above therapeutic level of an anticoagulation medication should be assessed for bleeding).

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38552 5. During a review of Resident 95's Admission Record, the Admission Record indicated the facility admitted the resident on 9/4/2024 with diagnoses including dementia (a progressive state of decline in mental abilities), generalized anxiety disorder (a mental health disorder that produces fear, worry, and a constant feeling of being overwhelmed), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 95's History and Physical (H&P), dated 9/8/2024, the H&P indicated, the resident does not have the capacity to understand and make decisions. During a review of Resident 95's Minimum Data Set (MDS-a resident assessment tool), dated 12/17/2024, the MDS indicated the resident sometimes had the ability to understand others and make self understood. The MDS indicated the resident was taking a high-risk anti-anxiety drug class medication. During a review of Resident 95's physician orders, dated 2/5/2025, the physician orders indicated to administer lorazepam 0.5 milligrams (mg-a unit of measurement) one tablet by mouth every four hours as needed for restlessness or shortness of breath. During a concurrent interview and record review on 3/14/2025 at 10:15 a.m. with MDS Nurse (MDSN) 1, Resident 95's physician progress notes, nursing progress notes, and physician orders from 2/4/2025 to 3/14/2025 were reviewed. MDSN 1 stated the lorazepam order for 30 days was handwritten in the physician order by Hospice Provider (HP) 1 and it was not transcribed in the electronic health record. MDSN 1 stated there should have been an end date for the PRN lorazepam. MDSN 1 stated it should have been transcribed accurately by the receiving licensed nurse and captured during the monthly recapitulation (a process of summarizing the resident's physician orders) of the resident's medication. MDSN 1 stated it should not have extended beyond 30 days without getting the proper order from the doctor. MDSN 1 stated the resident could be given unnecessary medication because there was no order. The Initial Psychiatric Evaluation indicated, on 3/11/2025, there was no documented rationale for the continued use of Resident 95's PRN lorazepam order. MDSN 1 stated the Initial Psychiatric Evaluation dated 3/11/2025 indicated no medication changes and to continue to monitor. During a concurrent interview and record review on 3/14/2025 at 10:29 a.m. with MDSN 1, Resident 95's Medication Administration Record 2/2025 and 3/2025 were reviewed. MDSN 1 stated four doses of lorazepam PRN were given to the resident after 3/6/2025, the 30th day from 2/5/2025. During an interview on 3/14/2025 at 3:02 p.m. with the Director of Nursing (DON), the DON stated, the purpose of indicating the duration on Resident 95's PRN lorazepam medication is to reevaluate the resident's need for it. The DON stated Resident 95 should have been evaluated by the hospice nurse and their hospice doctor then it should have been communicated to their facility if the resident still needed it. The DON stated lorazepam PRN ordered on 2/5/2025 would have ended on 3/6/2025 as 30th day and doses given after this date would have been unnecessary medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, last reviewed 9/27/2024, the P&P indicated psychotropic medication management includes duration. The P&P indicated Psychotropic medications are not prescribed or given on a PRN basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. a. PRN orders for psychotropic medications are limited to 14 days. (1) For Psychotropic medications that are NOT antipsychotics: If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order. 43455 Based on interview and record review, the facility failed to ensure five of five sampled residents' (Residents 79, 89, 8, 63, and 95) drug regimens were free from unnecessary (any medication in excessive dose, excessive duration, without adequate monitoring) psychotropic (a medication that affects brain activity associated with mental processes, emotions and behavior) medications by failing to: 1) Ensure Resident 79 had a specific, measurable target behavior related to the use of divalproex (a psychotropic medication used to decrease mood swings and aggressive outbursts. It may also be used as anticonvulsant [prevent seizures]) 2) Ensure Resident 79 had a detailed clinical rationale for continuing mirtazapine (an antidepressant [against depression] psychotropic medication used for increasing appetite) 3) Ensure Resident 89 had a specific, measurable target behavior related to the use of fluoxetine (an antidepressant psychotropic medication used for depression) These deficient practices had the potential to place Resident 79 and Resident 89 at risk for significant adverse effects (also known as side effects - unwanted, unintended result of medications) from the use of unnecessary antipsychotic drugs, which could result in impairment or decline in the resident's mental, physical condition, functional, and psychosocial status. 4) Obtain informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for Resident 8's use of sertraline (a psychotropic medication used to treat depression [persistent feelings of sadness and loss of interest that can interfere with daily living]) and divalproex sodium (a psychotropic medication used to treat severe mood swings). 5) Ensure Resident 8's sertraline and divalproex sodium were ordered, administered, and monitored for specific measurable targeted behaviors. 6) Ensure Resident 63's alprazolam (a psychotropic medication used to treat feelings of anxiousness) was ordered with a stop date and a documented clinical rationale. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	These deficient practices had the potential to result in the use of unnecessary psychotropic drugs and adverse effects (an undesired and harmful result of a treatment or intervention, such as a medication or surgery) of the medications to Residents 8 and 63. 7) Indicate the duration and evaluate the use of Resident 95's lorazepam medication used to manage anxiety [extreme fear or worry]) as needed (PRN) order. These deficient practices placed Resident 95 at risk of receiving an unnecessary psychotropic medication that could potentially result in the resident to experience harmful side effects. Findings: 1&2 During a review of Resident 79's Admission Record, the Admission Record indicated Resident 79 was originally admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis including major depressive disorder (having persistent sadness, loss of interest in activities, and other symptoms significantly affecting daily functioning) and persistent mood disorder (having persistently low mood, with low energy and difficulty in concentrating). During a review of Resident 79's Order Summary Report, dated 3/12/2025, the report indicated Resident 79 was prescribed: 1. Mirtazapine 7.5 mg give one (1) tablet by mouth at bedtime for depressive disorder manifested by loss of appetite, starting 9/17/2024 2. Divalproex 125 milligram ([mg] - a unit of measure of mass) give one (1) capsule by mouth twice a day for mood disorder manifested by extreme mood fluctuation, starting 9/18/2024 During a review of Resident 79's Minimum Data Set (MDS - a comprehensive resident assessment tool), dated 11/9/2024 and 2/8/2025, the MDS indicated Resident 79 had severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 79 had no mood or behavior symptoms, no symptoms of having little interest or pleasure in doing things, feeling down, depressed or hopeless. The MDS indicated Resident 79 received antidepressants on a routine basis, and the MDS dated [DATE] indicated Resident 79 also received anticonvulsants (Medication that help treat and prevent seizures. They can treat other conditions as well) on a routine basis. During a review of Resident 79's Mood Assessment report, dated 11/14/2024, the report indicated zero (0) behaviors for loss of interest, little interest or pleasure in doing things, zero (0) behaviors for sadness, feeling of appearing down, depressed or hopelessness, zero (0) behaviors irritability/agitation, being short-tempered, easily annoyed, zero (0) behaviors for change in appetite, poor appetite or overeating. During a review of Resident 79's Progress Notes, dated 12/27/2024, the report indicated Resident 79 had good appetite and was taking mirtazapine 7.5 mg at bedtime. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 79's Mood Assessment report, dated 2/4/2025, the report indicated zero (0) behaviors for loss of interest, little interest or pleasure in doing things, zero (0) behaviors for sadness, feeling of appearing down, depressed or hopelessness, zero (0) behaviors irritability/agitation, being short-tempered, easily annoyed, zero (0) behaviors for change in appetite, poor appetite or overeating. During a review of Resident 79's Progress Notes, dated 2/28/2025, the report indicated Resident 79 had a good appetite and was taking mirtazapine 7.5 mg at bedtime. During a review of Resident 79's Medication Administration Record ([MAR] - a record of mediations administered to residents) for February 2025, the MAR indicated Resident 79 had zero (0) behaviors of depression manifested by loss of appetite between 2/1/2025 and 2/28/2025. During a review of Resident 79's MAR for March 2025, the MAR indicated Resident 79 had zero (0) behaviors of depression manifested by loss of appetite between 3/1/2025 and 3/13/2025. During a review of Resident 89's Admission Record, (a document containing demographic and diagnostic information), the Admission Record indicated Resident 89 was originally admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis including major depressive disorder. During a review of Resident 89's Order Summary Report, dated 3/12/2025, the report indicated Resident 89 was prescribed: 1. Fluoxetine 10 mg one (1) tablet by mouth twice a day for depression manifested by persistent feelings of hopelessness/helplessness, starting 12/8/2023. During a review of Resident 89's MAR for March 2025, the MAR indicated Resident 89 was prescribed: 1. Fluoxetine 10 mg one (1) tablet by mouth twice a day for depression manifested by persistent feelings of hopelessness/helplessness, to be given at 9 a.m. During a review of Resident 89's Minimum Data Set (MDS - a comprehensive resident assessment tool), dated 2/8/2025, the MDS's indicated Resident 89 was cognitively intact. The MDS indicated Resident 89 had no mood or behavior symptoms, no symptoms of having little interest or pleasure in doing things, feeling down, depressed or hopeless. The MDS indicated Resident 89 received antidepressant on a routine basis. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/12/2025 at 2:40 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 79's divalproex order did not indicate a specific type of mood fluctuation behavior. LVN 1 stated there were many different type of mood fluctuations, such as going from sad to happy, angry to happy, angry to sad or happy to sad. LVN 1 stated without having a specific type of mood fluctuation to monitor, the behavior monitoring would vary between different licensed nurses and the physician will not be able to make an accurate assessment whether the divalproex was effective in reducing the specific behavior. LVN 1 stated as a result, divalproex maybe used unnecessarily causing harm by negatively affecting the physical and psychosocial well-being of Resident 79. During the same interview, LVN 1 stated Resident 89's fluoxetine order did not indicate the specific type of feelings of hopelessness/helplessness. LVN 1 stated that feeling was not a behavior but rather an emotion. LVN 1 stated there were many different types of hopelessness/helplessness, such verbalizing hopelessness or showing physical signs of not being able to do a task like getting out of bed, opening a book, turning on the television. LVN 1 stated without having a specific type of behavior monitor, the monitoring would vary between different licensed nurses and the physician will not be able to make an accurate assessment whether the fluoxetine was effective in reducing the specific behavior. LVN 1 stated as a result, fluoxetine maybe used unnecessarily causing harm by negatively affecting the physical and psychosocial well-being of Resident 89. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent record review and interview on 3/13/2025 at 10:41 a.m., with the Director of Nursing (DON,) the DON reviewed Resident 79's MDS, MAR, progress note and mood assessment reports. The DON stated Resident 79's order of divalproex for mood fluctuations was not targeting a specific behavior. The DON stated mood fluctuations was too general, unclear and open to interpretation by different licensed nurses. The DON stated not having specific behavior and condition monitoring could result in inaccurate assessment by the physician for the effectiveness of Resident 79's divalproex therapy. The DON stated that the facility failed to have individualized, person-centered care by monitoring a non-specific behavior for the use of divalproex for Resident 79, potentially resulting in the use of unnecessary psychotropic medication. During the same interview, the DON stated the MDS dated [DATE] and 2/8/2025, and Mood Assessment reports dated 11/14/2024 and 2/4/2025 indicated Resident 79 was not depressed and did not have poor appetite. The DON stated the February and March 2025 MARs indicated there were zero (0) documented behaviors for poor appetite. The DON stated the physician progress notes, dated 12/27/2024 and 2/28/2025, indicated Resident 79 had good appetite. The DON stated based on Resident 79 not exhibiting behaviors of poor appetite since November 2024 there should have been an attempt for a Gradual Dose Reduction (GDR) and/or documentation in the resident's chart indicating a clinical rationale for continuing mirtazapine at the originally prescribed dose or what clinical contraindications were present for not considering a GDR during that time. The DON stated the DON was unable to find a clinical rationale to continue the mirtazapine 7.5 mg at bedtime for Resident 79. The DON stated it was important to properly assess the absence of behaviors and consider GDR to ensure Resident 79 was receiving treatment that was optimal for Resident 79's condition and to maintain their highest level of well-being. The DON stated as a result, Resident 79 was placed at risk of continuing unnecessary psychotropic medications that could result in adverse consequences and side effects, negatively impacting the resident's well-being. The DON stated the facility and physician failed to document a clinical rationale for continuing the mirtazapine as originally prescribed for depression manifested by poor appetite on 9/17/2024, for Resident 79. During the same interview, the DON reviewed Resident 89's MDS dated [DATE] and March 2025 MAR. The DON stated Resident 89's order of fluoxetine for feelings of hopelessness/helplessness was not targeting a specific behavior. The DON stated feelings was not a specific behavior, and hopelessness/helplessness could either be verbalized or be shown by physical gestures. The DON stated not having specific behavior and condition monitoring could result in inaccurate assessment by the physician for the effectiveness of Resident 89's fluoxetine therapy. The DON stated that the facility failed to have individualized, person-centered care by monitoring a non-specific behavior for the use of fluoxetine for Resident 89, potentially resulting in the use of unnecessary psychotropic medication. During an interview on 3/18/2025 at 1:48 p.m., with the Consultant Pharmacist (CP,) the CP stated Resident 79's divalproex order needed to be monitored for a specific mood fluctuation, and Resident 89's fluoxetine order needed to be monitored for a specific behavior not a feeling. The CP stated not having a specific behavior to monitor, will lead to inaccurate monitoring and inability to measure efficacy of the medication therapy for Resident 79 and 89, resulting in the use of unnecessary psychotropic medications potentially leading to more harm than benefit. During a review of facility's policy and rocedures (P&P,) titled Psychotropic Medication Use, last reviewed 9/27/2024, the P&P indicated: Residents will not receive medications that are not clinically indicated to treat a specific condition. 1. A psychotropic medication is any medication that affects brain activity associated with mental processes and behavior. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: b. Anti-depressants 3. Residents who have not used psychotropic medications are not prescribed or given these medications unless is determined to be necessary to treat a specific condition that is diagnosed and documented in the clinical record. 11.Residents on psychotropic medications receive gradual dose reductions .unless clinically contraindicated in an effort to discontinue these medications. 12.When determining whether to initiate, modify, or discontinue medication therapy, the IDT conducts an evaluation of the resident. The evaluation will attempt to clarify whether: A. Signs and symptoms are clinically significant enough to warrant medication therapy B. A particular medication is clinically indicated to manage the symptoms or conditions. Review of the facility's P&P titled Behavior Assessment, Interventions and Monitoring, last reviewed 9/27/2024, the P&P indicated: 10. When medications are prescribed for behavioral symptoms, documentation will include: e. specific target behaviors and expected outcomes 4. IDT will monitor their indication and implement gradual dose reduction, or document why this cannot or should not be done. 44244 3. a. During a review of Resident 8's Admission Record (AR), the AR indicated the facility admitted the resident on 9/9/2024 and readmitted the resident on 2/14/2025, with diagnoses that included unspecified mood disorder (a mental health condition that primarily affects one's emotional state), dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that interfere with daily life) with other behavioral disturbances, generalized anxiety disorder (a mental health condition that may result in restlessness, irritability, feelings of nervousness, panic, and fear), and other symptoms and signs involving cognitive (relating to the mental process involved in knowing, learning, and understanding things) functions and awareness. During a review of Resident 8's History and Physical (H&P), dated 2/17/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 8's Minimum Data Set (MDS, resident assessment tool), dated 3/3/2025, the MDS indicated the resident had the ability to understand others and usually had the ability to make herself understood. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 8's Order Summary Report, the report indicated orders for the following: 1. Divalproex Sodium oral tablet delayed release 125 milligrams (mg, a unit of measure), give one tablet by mouth three times a day for psychosis (a mental state characterized by a loss of touch with reality and may involve hallucinations [seeing or hearing things that are not actually present] and delusions [beliefs not based on reality]) manifested by uncontrollable mood swings causing anger, dated 2/7/2025. 2. Sertraline HCL oral tablet 25 mg, give one tablet by mouth one time a day for depression manifested by inability to cope with daily activities causing anger, dated 2/14/2025. During a review of Resident 8's Informed Consent form for divalproex sodium, dated 2/14/2025, the Informed Consent form indicated the document was to be completed before treatment is initiated with psychotherapeutic drugs. The form was blank in the space provided for the resident/resident representative's signature. The form was blank in the space provided for the physician/prescriber's signature. During a review of Resident 8's Informed Consent form for sertraline, dated 2/14/2025, the Informed Consent form indicated the document was to be completed before treatment is initiated with psychotherapeutic drugs. The form was blank in the space provided for the resident/resident representative's signature. The form was blank in the space provided for the physician/prescriber's signature. During a concurrent interview and record review on 3/13/2025 at 11:21 a.m. with Minimum Data Set Nurse (MDSN) 1, MDSN 1 reviewed Resident 8's physician orders, Informed Consent form for sertraline dated 2/14/2025, and Informed Consent form for divalproex sodium dated 2/14/2025. MDSN 1 stated psychotropic medications are used to treat behavioral issues and have a risk of side effects like dizziness. MDSN 1 stated it was important to obtain informed consent to ensure residents and family members are aware of the risks of taking the medications. MDSN 1 state the process when a resident takes a psychotropic medication is the physician obtains informed consent from the resident/resident representative and consent is documented on the Informed Consent form before the medication is administered. MDSN 1 stated Resident 8 was administered sertraline three times a day and divalproex sodium daily for anger and there was no documented evidence that the physician had obtained informed consent from Resident 8's representative. MDSN 1 stated when consent was not obtained it could have potentially resulted in psychotropic medication administered without the family's consent resulting in side effects of unnecessary medications that may lead to injury from falls. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/13/2025 at 1:11 p.m. with the Director of Nursing (DON), the DON reviewed Resident 8's physician orders, Informed Consent form for sertraline dated 2/14/2025, and Informed Consent form for divalproex sodium dated 2/14/2025. The DON stated it is important that the physician explains the side effects of psychotropic medication so the resident and representatives may consider the risks verse the benefits of psychotropics in order to make an informed decision regarding the use of the medication. The DON stated there was no documented evidence that the physician obtained informed consent regarding Resident 8's sertraline or divalproex sodium. The DON stated if it was not documented then it was not done. The DON stated when the physician did not obtain consent from Resident 8's representative it could have potentially resulted in Resident 8's representative not being able to exercise their right to refuse or accept medications and Resident 8 being administered psychotropic medications against the family's wishes. The DON stated the facility policy was not followed. During a review of the facility policy and procedure (P&P) titled, Informed Consent, last reviewed 9/27/2024, the P&P indicated it was the policy of the facility to involve residents in their care decisions by facilitating information and obtaining consent for the use of psychotropic drugs. Psychotropic drugs are any drug that affects brain activities associated with mental processes and behavior. These drugs include but are not limited to drugs in the following categories: antipsychotic, anti-depressants, anti-anxiety, and hypnotic. The licensed provider will obtain an informed consent for the use of psychotropic drugs from the resident or legal representative. When a new order for the use of psychotherapeutic medication is made, the licensed nurse shall verify whether informed consent was obtained and document the verification process in the resident's clinical record on the Informed Consent form. Licensed nurse shall verify from the Resident and/or legal representative whether the consent has been obtained for the use of prescribed psychotherapeutic medication and will sign the form and document the name of the person who gave consent and the date when the consent was verified. During a review of the facility P&P titled, Psychotropic Medication Use, last reviewed 9/27/2024, the P&P indicated residents (and/or representatives) have the right to decline treatment with psychotropic medications. 3.b. During a review of Resident 8's Care Plan (CP) regarding sertraline, initiated 2/17/2025, the CP indicated to monitor and record episodes of behavior per psychotropic policy. During a review of Resident 8's CP) regarding divalproex sodium, initiated 2/17/2025, the CP indicated to monitor and record episodes per policy. During a concurrent interview and record review on 3/13/2025 at 11:21 a.m. with MDSN 1, MDSN 1 reviewed Resident 8's physician orders. MDSN 1 stated psychotropic medications have side effects like dizziness leading to falls and the goal is to have a gradual dose reduction (GDR) to reduce the amount of psychotropics administered to residents. MDSN 1 stated psychotropic medications are ordered with specific behaviors in order for staff to monitor for the effectiveness of the medication to determine if a GDR is possible. MDSN 1 stated Resident 8's sertraline order indicating inability to cope with daily activities causing anger was not a specific behavior to monitor. MDSN 1 stated Resident 8's divalproex sodium order indicating uncontrollable mood swings causing anger was not a specific behavior to monitor. MDSN 1 stated anger may be a behavior like yelling or hitting. MDSN 1 stated Resident 8 yells when she is angry. MDSN 1 stated Resident 8's psychotropic medication orders should have indicated the behavior of yelling in anger, but the orders did not. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/13/2025 at 1:11 p.m. with the DON, the DON reviewed Resident 8's physician orders. The DON stated psychotropic medication are ordered and monitored for specific behavioral indications. The DON stated a behavioral indication of anger is not specific because anger may manifest differently in residents and may also be interpreted differently by the monitoring staff. The DON stated when a specific behavior was not included with the psychotropic orders it could potentially lead to inaccurate monitoring of Resident 8's behavior. The DON stated when behaviors are not accurately monitored it may lead to psychotropic medication being unnecessarily administered leading to cognitive issues with increased confusion resulting in falls with fractures. During a review of the facility P&P titled, Psychotropic Medication Use, last reviewed 9/27/2024, the P&P indicated it residents will not receive medications that are not clinically indicated to treat a specific condition. A psychotropic medication is any medication that affects brain activity associated with mental processes and behavior. Psychotropic medication management includes adequate monitoring for efficacy. Residents on psychotropic medications receive gradual dose reductions (coupled with non-pharmacological interventions), unless clinically contraindicated, in an effort to discontinue these medications. When determining whether to initiate, modify, or discontinue medication therapy, the interdisciplinary team (IDT) conducts an evaluation of the resident. The evaluation will attempt to clarify whether: signs and symptoms are clinically significant enough to warrant medication therapy, and a particular medication is clinically indicated to manage the symptoms or condition. 4. During a review of Resident 63's AR, the AR indicated the facility admitted the resident on 5/8/2021, with diagnoses that included cerebral palsy (condition that affects movement and posture that occurs from damage to the brain during development), profound intellectual disabilities (significant challenges with understanding, learning, and adapting to everyday life, requiring constant support and supervision for basic needs), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with one's daily functioning). During a review of Resident 63's H&P, dated 5/3/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 63's MDS, dated [DATE], the MDS indicated the resident sometimes had the ability to understand others and sometimes had the ability to make himself understood. During a review of Resident 63's Order Summary Report, the Order Summary Report indicated an order for alprazolam oral tablet 1 mg, give one tablet by mouth as needed (PRN) for anxiety before any dental procedure, dated 2/19/2025. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/13/2025 at 9:15 a.m. with Registered Nurse (RN) 1, RN 1 reviewed Resident 63's physician orders. RN 1 stated all psychotropic medication ordered to be administered PRN must have a stop date of 14 days. RN 1 stated PRN psychotropic medications have a lot of side effects and must be re-evaluated every 14 days to ensure there is an ongoing need for the medication. RN 1 stated Resident 63 has anxiety during dental procedures and the dentist requested that the facility obtain an order for the anti-anxiety medication alprazolam to be given prior to the next dental appointment. RN 1 stated the facility obtained an order for alprazolam PRN on 2/19/2025, but Resident 63 did not yet have a dental appointment scheduled. RN 1 stated Resident 63's order for alprazolam was entered incorrectly as a PRN order with no stop date. RN 1 stated Resident 63 did not have an ongoing need for alprazolam and when it was ordered PRN without a stop date, there was the potential the medication may be administered for other reasons when it is not appropriate leading to side effects like drowsiness, lethargy, and dizziness which may lead to resident injury from falls. During a concurrent interview and record review on 3/14/2025 at 9:35 a.m. with the DON, the DON reviewed Resident 63's physician orders and the facility policy and procedure regarding psychotropic medications. The DON stated the facility policy indicates PRN psychotropic medication must have a stop date when a re-evaluation of the PRN medication is to be completed. The DON stated Resident 63 does not have an ongoing documented psychiatric issue that requires the use of PRN alprazolam, and the resident should not have been prescribed PRN alprazolam, but he was. The DON stated the facility process is to obtain a onetime order for alprazolam to be administered prior to the dental procedure, not a PRN order for alprazolam. The DON stated when Resident 63 had an order for PRN alprazolam without a stop date, it could have potentially led to the resident being administered unnecessary psychotropic medication with side effects like low blood pressure resulting in injury from falls. The DON stated the facility policy was not followed. During a review of the facility P&P titled, Psychotropic Medication Use, last reviewed 9/27/2024, the P&P indicated residents will not receive medications that are not clinically indicated to treat a specific condition. A psychotropic medication is any medication that affects brain activity associated with mental processes and behavior. Psychotropic medication management includes adequate monitoring for efficacy. Residents who have not used psychotropic medications are not prescribed or given these medications unless the medication is determined to be necessary to treat a specific condition that is diagnosed and documented in the medical record. Psychotropic medications are not prescribed or given on an as needed (PRN) basis unless that medication is necessa [TRUNCATED]

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five (5) percent (%). Four (4) medication errors out of 32 total opportunities contributed to an overall medication error rate of 12.5% affecting two (2) of three (3) residents observed for medication administration (Resident 21 and 77.) The medication errors were as follows: 1. Resident 21: a. Received carvedilol (a medication used to for hypertension [HTN - a condition in which the blood vessels have persistently raised pressure]) at a different time than ordered by Resident 21's physician. b. Received a form of multivitamin (a medication used as a dietary supplement to provide essential vitamins, minerals, and other nutritional elements) that was different than the one ordered by Resident 21's physician c. Did not receive PEG (a medication used to prevent cerebrovascular accidents [CVA] - an interruption in the flow of blood to cells in the brain] by thinning the blood) as ordered by Resident 21's physician 2. Resident 77 received carvedilol at a different time than ordered by Resident 77's physician. These failures had the potential to result in Resident 21 and 77 to experience medication adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) and the potential to result in Residents 21's and 77's health and well-being to be negatively impacted. Findings: During an observation on 3/11/2025 at 9:15 a.m. by Medication Cart East, Licensed Vocational Nurse (LVN) 1 was observed administering carvedilol 3.125 milligram ([mg]-a unit of measure of mass) tablet to Resident 77. Resident 77 was observed swallowing the carvedilol tablet with a glass of water. During an observation on 3/11/2025 at 9:27 a.m. by Medication Cart Middle, LVN 3 was observed administering carvedilol 25 mg tablet and multivitamin tablet orally, and not administering polyethylene glycol 3350 powder (a medication used for constipation) to Resident 21. Resident 21 was observed swallowing the carvedilol and multivitamin tablet with applesauce followed by glass of juice. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/11/2025 at 12:30 p.m., with LVN 3, LVN 3 stated she failed to prepare and administer polyethylene glycol 3350 powder and administered multivitamin to Resident 21, during the morning medication administration at 9:27 a.m. LVN 3 stated she failed to administer the correct multivitamin, polyethylene glycol 3350 powder, as prescribed by the physician. LVN 3 stated that not receiving multivitamin with minerals can harm Resident 21 by not getting the benefits from the minerals needed to maintain healthy kidneys. LVN 3 stated not administering polyethylene glycol could potentially harm Resident 21 by increasing the risk of having constipation. LVN 3 administered carvedilol at 9:27 a.m. instead of 7:15 a.m. that morning to Resident 21 because LVN 3 was busy with another resident. LVN 3 stated carvedilol needed to be administered with food to prevent stomach discomfort and increase the absorption of the medication. LVN 3 stated she failed to administer carvedilol as prescribed by Resident 21's physician placing Resident 21 at risk of having stomach irritation. LVN 3 stated these are all considered medication errors. LVN 3 stated that she will notify the physician for not administering polyethylene glycol and administering incorrect multivitamin and delaying carvedilol to Resident 21 and obtain additional orders as necessary. During an interview on 3/11/2025 at 12:50 p.m., with LVN 1, LVN 1 stated LVN 1 was busy with other residents and administered Resident 77's carvedilol at 9:15 a.m. that morning (3/11/2025). LVN 1 stated it was not possible to administer medications between 7 and 7:30 a.m. because LVNs were busy with hand off from previous shift and making resident rounds. LVN 1 acknowledged the physician's order specified to administer carvedilol at 7:15 a.m. with breakfast. LVN 1 stated breakfast is usually delivered around 7:30 a.m. LVN 1 stated, per facility policy, there was a 60-minute window for medication administration and LVN 1 administered carvedilol later than that timeframe. LVN 1 stated the carvedilol was scheduled to be administered at 7:15 a.m. with breakfast to prevent stomach discomfort and increase the absorption of the medication. LVN 1 stated LVN 1 failed to administer carvedilol as prescribed by Resident 77's physician and that a delay in medication administration was considered a medication error. During an interview 3/13/2025 at 10:41 a.m., with the Director of Nursing (DON), the DON stated LVN 1 failed to administer carvedilol 3.125 mg tablet to Resident 77 according to physician orders at 7:15 a.m. with breakfast, on 3/11/2025. The DON stated LVN 3 failed to administer carvedilol 25 mg tablet at 7:15 a.m. with breakfast, multivitamin with minerals and polyethylene glycol to Resident 21, according to physician orders on 3/11/2025. The DON stated these were considered medication errors. The DON stated Resident 21 and 77 may be at risk for developing stomach irritation from receiving carvedilol after 9 a.m. without a meal. The DON stated Resident 21 may possibly experience constipation by not receiving polyethylene glycol and be at risk of having mineral deficiency (lack of) by not receiving multivitamin with mineral. The DON stated licensed nurses should follow facility medication administration guidelines to ensure physician orders are followed and the right medications are administered at the right time to residents. During a review of Resident 21's Admission Record (a document containing demographic and diagnostic information), the Admission Record indicated the facility originally admitted Resident 21 to the facility on [DATE] and readmitted the resident on 1/25/2024 with diagnoses including HTN. During a review of Resident 21's Order Summary Report, dated 3/11/2025, the Order Summary Report indicated Resident 21 was prescribed: 1. Carvedilol 25 mg to give one (1) tablet by mouth twice a day for HTN administer with breakfast and dinner, starting 5/23/2024 (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Multivitamin with mineral to give one (1) tablet by mouth once a day for supplement, starting 1/26/2024 3. Polyethylene glycol 3350 powder to give 17 grams by mouth once a day for constipation, starting 1/26/2024 During a review of Resident 21's Medication Administration Record ([MAR] - a record of mediations administered to residents), for 3/2025, the MAR indicated Resident 21 was prescribed: 1. Carvedilol 25 mg (1) tablet by mouth twice a day for HTN administer with breakfast and dinner, to give at 7:15 a.m. and 5:15 p.m. 2. Multivitamin with mineral one (1) tablet by mouth once a day for supplement, to give at 9 a.m. 3. Polyethylene glycol 3350 powder 17 grams by mouth once a day for constipation, to give at 9 a.m. During a review of Resident 21's Medication Admin Audit Report, dated 3/12/2025, the Medication Admin Audit Report indicated Resident 21 received carvedilol 25 mg tablet on 3/11/2025 at 9:27 a.m. by LVN 3. During a review of Resident 77's Admission Record dated 3/11/2025, indicated Resident 77 was originally admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis including HTN. During a review of Resident 77's Order Summary Report, dated 3/11/2025, the Order Summary Report indicated Resident 77 was prescribed carvedilol 3.125 mg to give (1) tablet by mouth twice a day for HTN administer with breakfast and dinner, starting 1/3/2024. During a review of Resident 77's MAR for 3/2025, the MAR indicated Resident 77 was prescribed carvedilol 3.125 mg (1) tablet by mouth twice a day for HTN administer with breakfast and dinner, to give at 7:15 a.m. and 5:15 p.m. During a review of Resident 77's Medication Admin Audit Report, dated 3/12/2025, the Medication Admin Audit Report indicated Resident 77 received carvedilol 3.125 mg tablet on 3/11/2025 at 9:15 a.m. by LVN 1. During a review of the facility's policy and procedures (P&P), titled Administering Medications, last reviewed 9/27/2024, the P&P indicated Medications shall be administered in a safe and timely manner, and as prescribed. 3. Staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions. 4. Medications must be administered in accordance with the orders, including any required time frame. 7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	19. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and document the reason. 20. The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. During a review of the facility's P&P titled Medication Administration-General Guidelines, last reviewed 9/27/2024, the P&P indicated that Medications are administered as prescribed in accordance with good nursing principles and practices . Preparation 3. Prior to administration, the medication and dosage schedule on the resident's MAR is compared with the medication label. Administration 2. Medications are administered in accordance with written orders of the attending physician. 10. Medications are administered within 60 minutes of scheduled time (1 hour before and 1 hour after), except before or after meals, which are administered based on mealtimes. During a review of the facility's P&P, titled Adverse consequences and Medication Errors, last reviewed 9/27/2024, the P&P indicated: 1. Residents receiving any mediation that has a potential for an adverse consequence will be monitored to ensure that any such consequences are promptly identified and reported. 2. An 'adverse consequence' is defined as an unpleasant symptom or event that is due to or associated with a medication, such as an impairment or decline in an individual's mental or physical condition or functional or psychosocial status. An adverse consequence may include: a. Adverse drug/medication reaction b. Side effect 4. The staff and practitioner shall strive to minimize adverse consequences by: a. Following relevant clinical guidelines and manufacturer's specifications for use, dose, administration, duration, and monitoring of the medication; 5. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. 6. Examples of medication error include: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Omission - a drug is ordered but not administered; f. Wrong drug g. Wrong time h. Failure to follow manufacturer instructions and/or accepted professional standards. During a review of the facility's document, titled Meal Time and Locations and Menus, [undated], the document indicated: Meal Times: Breakfast - 7:15 am Lunch - 12:15 pm Dinner - 5:15 pm

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 43988 2. During a review of Resident 17's Admission Record, the Admission Record indicated the facility originally admitted the resident on 11/2/2021 and readmitted in the facility on 9/22/2024 with diagnoses including type two (2) diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing), long term use of insulin, and dementia (a progressive state of decline in mental abilities). During a review of Resident 17's History and Physical (H&P) dated 9/25/2024, the H&P indicated Resident 17 did not have the capacity to understand and make decisions. During a review of Resident 17's Minimum Data Set (MDS, a resident assessment tool) tool), dated 1/25/2025, the MDS indicated Resident 17 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and required substantial/maximal assistance to total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS further indicated Resident 17 received insulin. During a review of Resident 17's Order Summary Report, the Order Summary Report indicated the following physician's orders dated 9/22/2024: - Humalog injection solution 100 unit per milliliter (unit/ml - a unit of measurement) (insulin lispro - a short acting insulin). Inject subcutaneously before meals and at bedtime for DM 2, give insulin five (5) to ten (10) minutes before meals, rotate injection site. Inject as per sliding scale (increasing administration of the pre?meal insulin dose based on the blood sugar level before the meal): if 60 - 150 = 0; 151 - 200 = 1; 201 - 250 = 2; 251 - 300 = 3; 301 - 350 = 4; 351 - 400 = 5; 401+ = 6. Call physician (MD) if blood sugar is greater than 400 milligram per deciliter (mg/dl - a unit of measurement) or less than 70 mg/dl. During a concurrent interview and record review on 3/13/2025 at 10:38 a.m., reviewed Resident 17's physician's orders, Medication Administration Record (MAR - a daily documentation records used by a licensed nurse to document medications and treatments given to a resident) Location of Administration Report from 1/2025 to 3/2025, and the facility's policy and procedure (P&P) titled Adverse Consequences and Medication Error, with Registered Nurse (RN) 1. RN 1 stated Resident 17 had a physician's order for insulin lispro and were administered as follows: - Humalog injection solution 100 unit/ml (Insulin Lispro): 1/03/25 9:26 p.m. subcutaneously abdomen - left upper quadrant (LUQ) 1/04/25 4:14 p.m. subcutaneously abdomen - LUQ 1/24/25 11:18 a.m. subcutaneously abdomen - LUQ 1/24/25 3:42 p.m. subcutaneously abdomen - LUQ 1/24/25 9:00 p.m. subcutaneously abdomen - LUQ (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/27/25 9:53 p.m. subcutaneously abdomen - right lower quadrant (RLQ) 1/28/25 11:53 a.m. subcutaneously abdomen - RLQ RN 1 stated insulin administration sites should be rotated per standards of practice, manufacturer's guidelines, and according to physician's orders. RN 1 stated Resident 17's MAR indicated the insulin administration sites were not rotated and there was a physician's order to rotate injection sites. RN 1 stated Resident 17's insulin administration sites should have been rotated per standards of practice to prevent pain, redness, irritation, bruising, and pits on the resident's skin. RN 1 stated not following physician's orders, manufacturer's guideline, and standards of practice to rotate insulin administration sites can be considered a medication error as indicated in the facility P&P. During an interview on 3/14/2025 at 2:45 p.m. with the Director of Nursing (DON), the DON stated the Licensed Nurses (LN) should have rotated Resident 17's insulin injection site to prevent bleeding, thinning of the skin, and injury to the site. The DON further stated to prevent development of lipodystrophy. The DON the LN should have followed the manufacturer's guideline and physician's order to rotate injection sites. The DON stated not following physician's orders, manufacturer's guideline, and standards of practice regarding rotation of insulin administration sites was considered a medication error. During a review of the facility provided manufacturer's guideline for insulin lispro, undated, the manufacturer's guideline indicated: - Change (rotate) your injection sites within the area you choose for each dose to reduce your risk of getting lipodystrophy (pits in skin or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. - Do not inject where the skin has pits, is thickened, or has lumps. - Do not inject where the skin is tender, bruised, scaly or hard, or into scars or damaged skin. - Choose your injection site: insulin lispro is injected under the skin of your stomach area, buttocks, upper legs or upper arms. During a review of the facility's recent P&P titled Insulin Administration, last reviewed on 9/27/2024, the P&P indicated a purpose to provide guideline for the safe administration of insulin to residents with diabetes. The P&P further indicated: - Select an injection site: a. Insulin may be injected into the subcutaneous tissue of the upper arm and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's recent P&P titled, Adverse Consequences and Medication Errors, last reviewed 9/27/2024, the P&P indicated a medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. 3. During a review of Resident 48's Admission Record, the Admission Record indicated the facility originally admitted the resident on 4/27/2024 and readmitted in the facility on 1/29/2025 with diagnoses including type two (2) diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing), congestive heart failure (CHF - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and generalized weakness. During a review of Resident 48's History and Physical (H&P) dated 1/30/2025, the H&P indicated Resident 48 had the capacity to understand and make decisions. During a review of Resident 48's Minimum Data Set (MDS, a resident assessment tool) tool), dated 2/5/2025, the MDS indicated Resident 48 had an intact cognition (mental action or process of acquiring knowledge and understanding) and required supervision or touching assistance with eating and oral hygiene, partial/moderate assistance with upper body dressing, and substantial/maximal assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS further indicated Resident 48 received insulin. During a review of Resident 48's Order Summary Report, the Order Summary Report indicated the following physician's orders dated 1/29/2025: - Insulin glargine (a long-acting insulin) subcutaneous solution pen-injector 100 unit/ml inject eight (8) unit subcutaneously in the morning for DM 2. Administer before breakfast (rotate injection sites) hold for fingerstick blood sugar (FSBS) less than (<) 100. - Insulin Lispro (1 unit Dial) subcutaneous solution pen-injector 100 unit/ml Inject subcutaneously before meals and at bedtime for DM 2 for FSBS more than 400 give 12 units and call MD. Notify MD if blood sugar is above 400 or below 60; give insulin 5 - 10minutes before mealtime, may give orange juice eight (8) ounces (oz) or glucose gel by mouth if blood sugar below 60. Inject as per sliding scale: if 60 - 150 = 0 unit; 151 - 200 = 2 units; 201 - 250 = 4 Units; 251 - 300 = 6 Units; 301 - 350 = 8 Units; 351 - 400 = 10 Units. During a concurrent interview and record review on 3/13/2025 at 10:45 a.m., reviewed Resident 48's physician's orders, Medication Administration Record (MAR - a daily documentation records used by a licensed nurse to document medications and treatments given to a resident) Location of Administration Report from 1/2025 to 3/2025 with Registered Nurse (RN) 1. RN 1 stated Resident 48 had a physician's order for insulin lispro and insulin glargine and were administered as follows: - Insulin glargine subcutaneous solution pen-injector 100 unit/ml: 2/03/25 6:15 a.m. subcutaneously abdomen - left lower quadrant (LLQ) 2/04/25 7:18 a.m. subcutaneously abdomen - LLQ (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/13/25 7:11a.m. subcutaneously abdomen - LLQ 2/14/25 7:19 a.m. subcutaneously abdomen - LLQ 2/19/25 7:05 a.m. subcutaneously abdomen - left upper quadrant (LUQ) 2/20/25 6:52 a.m. subcutaneously abdomen - LUQ - Insulin lispro subcutaneous solution pen-injector 100 unit/ml: 2/02/25 9:17 p.m. subcutaneously abdomen - right lower quadrant (RLQ) 2/03/25 9:38 p.m. subcutaneously abdomen - RLQ 2/10/25 9:56 p.m. subcutaneously abdomen - right upper quadrant (RUQ) 2/12/25 8:57 p.m. subcutaneously abdomen - RUQ RN 1 stated insulin administration sites should be rotated per standards of practice, manufacturer's guidelines, and according to physician's orders. RN 1 stated Resident 17's MAR indicated the insulin administration sites were not rotated and there was a physician's order to rotate injection sites. RN 1 stated Resident 17's insulin administration sites should have been rotated per standards of practice to prevent pain, redness, irritation, bruising, and pits on the resident's skin. RN 1 stated not following physician's orders, manufacturer's guideline, and standards of practice to rotate insulin administration sites can be considered a medication error as indicated in the facility P&P. During an interview on 3/14/2025 at 2:45 p.m. with the Director of Nursing (DON), the DON stated the Licensed Nurses (LN) should have rotated Resident 17's insulin injection site to prevent bleeding, thinning of the skin, and injury to the site. The DON further stated to prevent development of lipodystrophy. The DON the LN should have followed the manufacturer's guideline and physician's order to rotate injection sites. The DON stated not following physician's orders, manufacturer's guideline, and standards of practice regarding rotation of insulin administration sites was considered a medication error. During a review of the facility provided manufacturer's guideline for insulin lispro, undated, the manufacturer's guideline indicated: - Change (rotate) your injection sites within the area you choose for each dose to reduce your risk of getting lipodystrophy (pits in skin or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. - Do not inject where the skin has pits, is thickened, or has lumps. - Do not inject where the skin is tender, bruised, scaly or hard, or into scars or damaged skin. - Choose your injection site: insulin lispro is injected under the skin of your stomach area, buttocks, upper legs or upper arms. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's recent policy and procedure(P&P) titled Insulin Administration, last reviewed on 9/27/2024, the P&P indicated a purpose to provide guideline for the safe administration of insulin to residents with diabetes. The P&P further indicated: - Select an injection site: a. Insulin may be injected into the subcutaneous tissue of the upper arm and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility's recent P&P titled, Adverse Consequences and Medication Errors, last reviewed 9/27/2024, the P&P indicated a medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. 44376 Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors (means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards) to three of 4 sampled residents (Residents 107, 17, and 48) reviewed for insulin (a hormone that lowers the level of glucose [a type of sugar] in the blood) by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (beneath the skin) insulin administration sites. The deficient practices had the potential for adverse effect (unwanted, unintended result) of same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Cross Reference F658 Findings: 1. During a review of Resident 107's Admission Record, the Admission Record indicated the facility admitted the resident on 2/17/2025, with diagnoses including type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), lack of coordination, and chronic kidney disease stage 3 (when the kidneys have mild to moderate damage and are less able to filter waste and fluid out of the blood). During a review of Resident 107's History and Physical (H&P), dated 2/19/2025, the H&P indicated the resident was alert and oriented to person, place, and time. The H&P indicated the resident had the capacity to understand and make decisions. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 107's Minimum Data Set (MDS, a resident assessment tool), dated 2/23/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a participant who has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). The MDS indicated the resident was on a high-risk drug class hypoglycemic medication (a group of drugs used to help reduce the amount of sugar present in the blood). During a review of Resident 107's Order Summary Report, the Order Summary Report indicated an order for: 2/17/2025 Insulin Aspart Solution 100 unit per milliliters (unit/ml, a milliliter is a unit of fluid volume equal to one-thousandth of a liter). Inject 6 unit subcutaneously before meals for diabetes mellitus type 2 (DM2). Administer before breakfast. 2/20/2025 Insulin Glargine Solution 100 unit/ml. Inject 15 unit subcutaneously every 12 hours for DM2. During a review of Resident 107's Location of Administration Report of Insulin for 2/2025 to 3/2025, the Location of Administration Report indicated Insulin Glargine Solution 100 unit/ml was administered subcutaneously on: 2/22/2025 at 9:40 a.m. at the Abdomen - Left Lower Quadrant (LLQ) 2/22/2025 at 9 p.m. at the Abdomen - LLQ 2/22/2025 at 10:41 a.m. at the Abdomen - Left Upper Quadrant (LUQ) 2/22/2025 at 4:30 p.m. at the Abdomen - LUQ 2/24/2025 at 4:19 p.m. at the Abdomen - LLQ 2/25/2025 at 7:16 a.m. at the Abdomen - LLQ 2/27/2025 at 5:27 p.m. at the Abdomen - LUQ 2/28/2025 at 7:09 a.m. at the Abdomen - LUQ During a concurrent interview and record review on 3/13/2025, at 10:33 a.m., with Registered Nurse (RN) 1, reviewed Resident 107's Order Summary Report and Location of Administration Report of Insulin for 2/2025 to 3/2025. RN 1 stated there were multiple times where the insulin administration sites were not rotated from 2/2025 to 3/2025 for Resident 107. RN 1 stated the licensed nurses should rotate insulin administration sites to prevent phlebitis (an inflammation that causes a blood clot to form in a vein, usually in the leg), hematoma (a pool of mostly clotted blood that forms in an organ, tissue, or body space), pain, and lipodystrophy on residents. RN 1 stated not rotating insulin administration site is a medication error. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/14/2025, at 11:37 a.m., with the Director of Nursing (DON), inside the facility's conference room, the DON stated the licensed nurses should have rotated the insulin administration sites of Resident 107 to prevent bleeding, thinning of the skin, injury to the site, and lipodystrophy on the resident. The DON stated not rotating insulin administration site is a medication error. During a review of the facility's recent policy and procedure (P&P) titled Adverse Consequences and Medication Errors, last reviewed on 9/27/2024, the P&P indicated a medication error is defined as the preparation or administration of drugs or biologicals which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. During a review of the facility's recent P&P titled Insulin Administration, last reviewed on 9/27/2024, the P&P indicated to provide guidelines for the safe administration of insulin to residents with diabetes. Select an injection site. a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility-provided Highlights of Prescribing Information on the use of Lantus (insulin glargine injection) for subcutaneous injection, with initial U.S. approval in 2000, the Highlights of Prescribing Information indicated to rotate injections sites to reduce the risk of lipodystrophy.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44244 Based on observation, interview, and record review, the facility failed to ensure drugs were labeled in accordance with currently accepted professional principles to facilitate consideration of precautions and safe administration of medications by failing to ensure intravenous (administered within a vein) meropenem (medication used to treat a wide range of bacterial infections) was labeled with the resident's name for one of two sampled residents (Resident 109) reviewed under the Antibiotic care area. This deficient practice had the potential to result in medication administration to the wrong resident resulting in adverse effects (an undesired and harmful result of a treatment or intervention, such as a medication or surgery) of medication. Findings: During a review of Resident 109's Admission Record (AR), the AR indicated the facility admitted the resident on 12/6/2024 and readmitted the resident on 3/10/2025, with diagnoses that included malignant neoplasm (cancer) of prostrate (small gland in the male reproductive system, located below the bladder), and urinary tract infection (UTI- an infection in the bladder/urinary tract), During a review of Resident 109's History and Physical (H&P), dated 3/11/2025, the H&P indicated the resident did not have the capacity to make medical decisions. During a review of Resident 109's Minimum Data Set (MDS, resident assessment tool), dated 12/17/2024, the MDS indicated the resident had the ability to understand others and had the ability to make himself understood. During a review of Resident 109's Order Summary Report, the Order Summary Report indicated a physician order dated 3/11/2025 for meropenem intravenous solution reconstituted one gram (gm, a unit of measurement), use one gm intravenously every 12 hours for UTI until 3/17/2025. During a concurrent observation and interview on 3/11/2025 at 10 a.m., observed Resident 109 lying on bed while being administered meropenem intravenously. Observed the medication solution bag was labeled with a handwritten label indicating meropenem, 1 gm intravenously at 9 a.m., 3/11/2025, and the nurse's initials. Observed the label did not indicate the resident's name. Resident 109 stated Resident 109 had just returned from the hospital on 3/10/2025. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 3/11/2025 at 10:05 a.m., with Registered Nurse (RN) 1, RN 1 entered Resident 109's room and stated the resident had just returned from the hospital and required meropenem every twelve hours. RN 1 stated the pharmacy had not yet delivered Resident 109's meropenem, so a dose was removed from the emergency medication kit (e-kit - emergency drug supplies). RN 1 stated the nurse labels the medication from the e-kit prior to administration with the medication name, route, date and time, dose, and resident name. RN 1 stated all medication should be labeled so the administering nurse can check the medication label against the resident wrist band to ensure the right resident gets the right medication at the right time. RN 1 assessed Resident 109's meropenem and stated the label did not indicate the resident's name and it was an oversite. RN 1 stated when Resident 109's meropenem was not labeled with the resident's name it could potentially result in the wrong resident receiving medication not intended for them leading to adverse effects like allergic reactions. During a concurrent interview and record review on 3/14/2025 at 9:35 a.m., with the Director of Nursing (DON), the DON reviewed the facility policy and procedures (P&P) regarding medication labeling. The DON stated there is usually a label to complete and attach to the IV medication from the E-kit, but that was not done for Resident 109's meropenem. The DON stated it was important to label the IV medication from the E-kit with the resident's name because the administering nurse needs to do triple checks when administering medication to make sure the right medication is administered to the right resident. The DON stated the facility P&P was not followed when Resident 109's meropenem was not labeled with the resident's name and it could potentially result in the medication being administered to the wrong resident leading to an adverse allergic reaction or unnecessary medication administration. During a review of the facility P&P titled, Labeling of Medication Containers, last reviewed 9/27/2024, the P&P indicated all medications maintained in the facility are properly labeled in accordance with current state and federal guidelines and regulations. Medication labels must be legible at all times. Labels for individual resident medications include all necessary information, such as the resident's name. Labels for each single unit dose package include all necessary information, such as the name of the resident. The names of the resident and physician do not have to be on each unit dose package, but they must be identified with the package in such a manner as to ensure that the drug is administered to the right resident. During a review of the facility P&P titled, Administering Medications, last reviewed 9/27/2024, the P&P indicated medications are administered in a safe and timely manner. The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. 38552 Based on interview and record review, the facility failed to follow-up with the endocrinologist when Resident 77's hemoglobin A1C (HbA1c-a test that indicates the average level of blood sugar control over the last couple of months, a high number is a sign of poor blood sugar control) test result was reported to the facility for one of five sampled residents (Resident 77) reviewed under Unnecessary Meds, Psychotropic (medications capable of affecting the mind, emotions, and behavior) Meds, and Med Regimen Review Care Area. This deficient practice placed Resident 77 at risk for uncontrolled Hb1A1c levels which could lead to hyperglycemia (high blood sugar), kidney damage, and make the resident susceptible to infections and poor wound healing. Findings: During a review of Resident 77's Admission Record, the Admission Record indicated the facility admitted the resident on 11/5/2022 with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic neuropathy (a complication of diabetes that damages the nerves throughout the body), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should). During a review of Resident 77's Lab Results Report, dated 11/8/2024, the Lab Results Report indicated Resident 77's HbA1c test result measured nine percent (%-a unit of measurement, normal range 4.0 - 6.0 %). During a review of Resident 77's Care Plan (CP) Report titled diabetes mellitus (DM) focus, dated 11/22/2024, the CP Report included interventions for labs as ordered and assessing baseline. During a review of Resident 77's Minimum Data Set (MDS-a resident assessment tool), dated 2/9/2025, the MDS indicated the resident had intact cognitive skills (mental action or process of acquiring knowledge and understanding) and was taking hypoglycemic (lowers blood sugar) medication including insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) medication. During a review of Resident 77's History and Physical (H&P), dated 2/28/2025, the H&P indicated the resident has the capacity to understand and make decisions. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/14/2025 at 10:36 a.m. with MDS Nurse (MDSN) 1, Resident 77's Progress Notes from 11/6/2024 to 11/14/2024 were reviewed. MDSN 1 stated the Progress Notes, dated 11/8/2024 at 1:26 p.m., indicated the resident's attending was notified and to relay the lab results to the resident's endocrinologist. MDSN 1 stated the Progress Notes indicated they were waiting for orders. MDSN 1 stated there was no follow-up documentation the next day, 11/9/2024. MDSN 1 stated there should have been a follow-up to the resident's endocrinologist on 11/9/2024. MDSN 1 stated the follow-up is done to see if any medication adjustments would be needed in the management of the resident's diabetes management. MDSN 1 stated the resident potentially can have hyperglycemia, uncontrolled blood sugar levels, symptoms would include polyuria (excessive urination), polyphagia which is excessive/uncontrollable eating and excessive drinking can affect the resident's kidneys. MDSN 1 stated with hyperglycemia the resident is also at risk for urinary tract infection (UTI- an infection in the bladder/urinary tract) and poor wound healing. During a review of the facility's policy and procedures (P&P) titled, Test Results, last reviewed 9/27/2024, the P&P indicated the resident's attending physician will be notified of the results of the diagnostic tests. The P&P indicated Should the test results be provided to the facility; the attending physician shall be promptly notified of the results. The director of nursing services, or charge nurse receiving the test results, shall be responsible for notifying the physician of such test results. Signed and dated reports of all diagnostic services shall be made a part of the resident's medical record.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 44376 Based on observation, interview, and record review, the facility failed to ensure proper sanitation and food handling practices by failing to ensure a pitcher of cranberry juice stored in the refrigerator in the kitchen was labeled with the date it was poured on the container. These deficient practices had the potential to cause food-borne illnesses (also known as food poisoning, a sickness from eating or drinking contaminated food or beverages, often causing symptoms like nausea, vomiting, and diarrhea). Findings: During a kitchen observation tour and interview on [DATE], at 10:35 a.m., with the Dietary Manager (DM), inside the facility's kitchen, observed a pitcher of cranberry juice stored in the kitchen refrigerator without the date it was poured on the pitcher. The DM stated the staff should have dated the pitcher of cranberry juice once poured to ensure the cranberry juice was fresh and not passed it best use by date to prevent food-borne illness to residents due to ingestion of potentially expired drinks. During an interview on [DATE], at 11:37 a.m., with the Director of Nursing (DON), inside the facility's conference room, the DON stated the dietary staff should have labeled the pitcher of cranberry juice with the date it was poured on the pitcher to know how old the cranberry juice is. The DON stated there is a potential for residents to experience stomach problems such as nausea, vomiting, and diarrhea when they consume the old cranberry juice inside the pitcher. During a review of the facility's recent policy and procedure (P&P) titled Food Receiving and Storage, last reviewed on [DATE], the P&P indicated foods shall be received and stored in a manner that complies with safe food handling practices. All foods stored in the refrigerator or freezer are covered , labeled and dated (use by date).

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Deficiency Text Not Available

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 43455 Based on interview and record review, the facility failed to revise and provide a current staffing plan in the Facility's Assessment (evaluates the resident population and determines what resources are necessary to care for residents competently during both day-to-day operations [including nights and weekends] and emergencies) to meet resident's needs. This deficient practice placed the residents at risk for lack or delay of care and treatment services and resulted in Resident 21 and 77 receiving medications at later time than scheduled. Cross reference F759 Findings: During an interview on 3/11/2025 at 12:30 p.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 stated she administered carvedilol at 9:27 a.m. instead of 7:15 a.m. that morning to Resident 21 because LVN 3 was busy with another resident. LVN 3 stated carvedilol needed to be administered with food to prevent stomach discomfort and increase the absorption of the medication. LVN 3 stated she failed to administer carvedilol as prescribed by Resident 21's physician and that a delay in medication administration was considered a medication error. During an interview on 3/11/2025 at 12:50 p.m., with LVN 1, LVN 1 stated LVN 1 was busy with other residents and administered Resident 77's carvedilol at 9:15 a.m. that morning (3/11/2025). LVN 1 stated it was not possible to administer medications between 7 and 7:30 a.m. because LVNs were busy with hand off from previous shift and making resident rounds. LVN 1 acknowledged the physician's order specified to administer carvedilol at 7:15 a.m. with breakfast. LVN 1 stated breakfast is usually delivered around 7:30 a.m. LVN 1 stated, per facility policy, there was a 60-minute window for medication administration and LVN 1 administered carvedilol later than that timeframe. LVN 1 stated the carvedilol was scheduled to be administered at 7:15 a.m. with breakfast to prevent stomach discomfort and increase the absorption of the medication. LVN 1 stated LVN 1 failed to administer carvedilol as prescribed by Resident 77's physician and that a delay in medication administration was considered a medication error. During an interview on 3/12/2025 at 11:30 a.m., LVN 1 stated LVN 1 did not administer carvedilol at 7:15 a.m. to Resident 21 that morning (3/12/2025) as the resident was sleeping but failed to document as such because LVN 1 was busy that morning with a lot of residents assigned to LVN 1. LVN 1 stated LVN 1 was assigned over 40 residents that day. LVN 1 stated LVN 1's shift started at 7 a.m. and it takes about 30 minutes to take blood pressure measurements from the residents, an additional 20 to 30 minutes for hand off information from previous shift nurse, medication cart checks, and rounding on 40 residents, resulting in LVN 1 failing to administer medications timely specially those scheduled prior to 8 a.m. LVN 1 stated to provide good care to residents there should be less number of residents assigned per LVN. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/13/2025 at 8:10 a.m., with LVN 4, LVN 4 stated she did not administer carvedilol at 7:15 a.m. to Resident 21 that morning as LVN 4 was busy with another resident. LVN 4 stated it was impossible to administer medications scheduled at 7:15 a.m. timely, as LVN 4s shift starts at 7 a.m. and usually takes at least 30 minutes to for hand off information, rounding on residents and medication cart checks. LVN 4 stated with the number of residents assigned it takes LVN 4 until 11 a.m. to complete medication administrations. During an interview on 3/13/2025 at 8:40 a.m., with the Administrator (ADM) and in the presence of the Director of Nursing (DON,) the ADM stated the Facility Assessment, dated 12/1/2024, indicated a ratio of 1 LVN to 24 residents (1:24). The ADM stated a new assessment was needed when the facility acuity (a measure of severity of illness of residents) changed. The ADM stated there was no new assessment done since 12/1/2024, and the facility failed to follow the Facility Assessment by maintaining a ratio of 1 LVN to 24 residents (1:24). During an interview on 3/13/2025 at 8:51 a.m., with the Administrator (ADM), the ADM stated 2 additional LVNs were just called in to assist with medication administration that day (3/13/2025.) During a concurrent observation and interview on 3/13/2025 at 10:05 a.m., LVN 4 was still passing 9 a.m. medications. LVN 4 stated she was still passing 9 a.m. medications and that per facility policy there was a one (1) hour window before and after 9 a.m. to administer medications. LVN 4 stated it was 10 a.m. and that LVN 4 still needed to administer medications to Resident 15, 16, 113, 271 and 273. LVN 4 stated with the number of residents assigned to LVN 4 there was not enough time to complete medication administration by 10 a.m. LVN 4 stated more LVNs are needed to administer medications timely and be compliant with Medication Administration policy. During a review of Facility Assessment, dated 12/1/2024, the Facility Assessment indicated a staffing need of 1 LVN per 24 residents during the day shift. During a review of Staffing Assignment between 3/11/2025 and 3/13/2025, the assignment indicated: 3/11/2025 Day Shift 7 a.m. to 3 p.m. LVN 2 - ratio 1:36 3/11/2025 Day Shift 7 a.m. to 3 p.m. LVN 1 - ratio 1:40 3/11/2025 Day Shift 7 a.m. to 3 p.m. LVN 3 - ratio 1:45 3/12/2025 Day Shift 7 a.m. to 3 p.m. LVN 5 - ratio 1:36 3/12/2025 Day Shift 7 a.m. to 3 p.m. LVN 1 - ratio 1:40 3/12/2025 Day Shift 7 a.m. to 3 p.m. LVN 3 - ratio 1:45 3/13/2025 Day Shift 7 a.m. to 3 p.m. LVN 1 - ratio 1:40 3/13/2025 Day Shift 7 a.m. to 3 p.m. LVN 2 - ratio 1:36 3/13/2025 Day Shift 7 a.m. to 3 p.m. LVN 3 - ratio 1:45 (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P,) titled Facility Assessment, last reviewed on 9/27/2024, the P&P indicated: A facility assessment is conducted annually to determine and update our capacity to meet the needs of and competently care for our residents during day-to-day operations. Determining our capacity to meet the needs of and care for our residents during emergencies is included in this assessment. 1. Once a year, and as needed a designated team conducts a facility-wide assessment to ensure that the resources are available to meet the specific needs of our residents. 6. The facility assessment is intended to help our facility plan for and respond to changes in the needs of our resident population and helps to determine budget, staffing, training, equipment, and supplies needed. It is separate from the Quality Assurance and Performance Improvement evaluation. 9. The facility assessment is reviewed and updated annually, and as needed. Facility or resident changes or modifications that may prompt a reassessment sooner include: c. a significant change in the resident census and/or overall acuity of our residents.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 43988 Based on interview and record review, the facility failed to maintain medical records within accepted professional standards for one of eight sampled residents (Resident 17) reviewed for accidents by failing to complete the elopement risk assessment accurately. This deficient practice had the potential to result in inaccurate documentation in the medical record regarding Resident 17's elopement risk status. Findings: During a review of Resident 17's Admission Record, the Admission Record indicated the facility originally admitted the resident on 11/2/2021 and readmitted the resident on 9/22/2024 with diagnoses including cerebral infarction (also known as stroke, loss of blood flow to a part of the brain) and dementia (a progressive state of decline in mental abilities). During a review of Resident 17's History and Physical (H&P) dated 9/25/2024, the H&P indicated Resident 17 did not have the capacity to understand and make decisions. During a review of Resident 17's Minimum Data Set (MDS, a resident assessment tool) tool), dated 1/25/2025, the MDS indicated Resident 17 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and required substantial/maximal assistance to total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 17's Elopement Risk Assessments dated 10/25/2024 and 1/24/2025, the Elopement Risk Assessments indicated Resident 17 was a t risk for elopement or wandering with a score of 10 and the summary of review indicated resident was not a risk for elopement or wandering. During a concurrent interview and record review on 3/13/2025 at 1:56 p.m., reviewed Resident 17's Elopement Risk Assessments dated 10/25/2024 and 1/25/2025 with MDS Nurse (MDSN) 2. MDSN 2 stated the Elopement Risk Assessments she completed indicated Resident 17 had a score of ten, the resident was at risk for elopement or wandering, and the summary of review indicated Resident 17 was not a risk for elopement or wandering. MDSN 2 stated the Elopement Risk Assessments indicated a score of 10 and above meant the resident was at risk for elopement or wandering. MDSN 2 stated scores are calculated automatically by the electronic health record system based on the resident's condition at the time of assessment. MDSN 2 stated she should have documented in the summary of review that Resident 17 was a risk for elopement based on the calculated score of 10. MDSN 2 stated it was a documentation error and it had the potential for inaccurate documentation in Resident 17's medical record which may lead to confusion regarding the resident's current status. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/13/2025 at 3 p.m. with MDSN 1, MDSN 1 stated the Elopement Risk Assessments are completed during admission, quarterly, and as needed. MDSN 1 stated Resident 17's Elopement Risk Assessments dated 10/25/2024 and 1/25/2025 should have been completed accurately to reflect at the summary of review that the resident was at risk for elopement to avoid confusion with the resident's current status when the staff reviewed Resident 17's Elopement Risk Assessments. MDSN 1 stated it was a documentation error. During a review of the facility's policy and procedures (P&P) titled Charting and Documentation, last reviewed on 9/27/2024, the P&P indicated: - The following is to be documented in the resident medical record: objective observations, and events, incidents or accidents involving the resident. - Documentation in the medical record will be objective, complete, and accurate.

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide a neutral and fair arbitration process and agree to arbitrator and venue. 44244 Based on interview and record review, the facility failed to ensure fairness and integrity of the binding arbitration process (method of resolving disputes outside of court) when one of three sampled residents (Resident 3) reviewed under the Arbitration Agreement (AA - legal document agreeing to arbitration) task, was offered and entered into an AA that failed to provide for the selection of a neutral arbitrator (impartial, or unbiased third-party decision maker) agreed upon by both parties and for the selection of a venue that was convenient to both parties. This deficient practice had the potential to cause psychosocial harm to residents during the binding arbitration process. Findings: During a review of Resident 3's Admission Record (AR), the AR indicated the facility admitted the resident on 3/24/2007 and readmitted the resident on 9/4/2024, with diagnoses that included metabolic encephalopathy a (general term that describes brain disease, damage, or malfunction usually related to inflammation within the body), acute on chronic respiratory failure (a serious condition that occurs when the lungs cannot get enough oxygen), and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 3's History and Physical (H&P), dated 9/6/2024, the H&P indicated the resident has expressive aphasia (difficulty verbalizing) and had the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS, resident assessment tool), dated 10/15/2024, the MDS indicated the resident usually had the ability to understand others and usually had the ability to make herself understood. The MDS further indicated the resident had moderately impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). During a review of Resident 3's Resident - Facility AA (R-FAA) revised 3/2007, dated and signed on 11/14/2023 by the resident's representative (RR), the R-FAA indicated an agreement to have all monetary disputes decided by arbitration. The R-FAA further indicated the resident was giving up all their rights to a jury or court trial. The R-FAA did not provide for the selection of a neutral arbitrator agreed upon by both parties or provide for the selection of a venue that was convenient to both parties. (continued on next page)

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/14/2025 at 8:49 a.m. with the Admission's Coordinator (AC), the AC reviewed Resident 3's R-FAA revised 3/2007 and dated 11/14/2023, and a blank sample of the R-FAA revised 11/2019. The AC stated the R-FAA was important because a resident was giving up their constitutional right to a jury or court trial. The AC stated upon admission the AC discusses the R-FAA and the resident or resident representative signs the agreement. The AC reviewed the blank R-FAA revised 11/2019 and noted the R-FAA specifically indicated the selection of a neutral arbitrator and to provide for the selection of a venue that was convenient to both parties. The AC reviewed Resident 3's R-FAA revised 3/2007 and noted the agreement did not specifically indicate the selection of a neutral arbitrator or the selection of a venue that was convenient to both parties. The AC stated he did not know why Resident 3's RR signed the old version of the R-FAA because the AC did not work for the facility in 2023. The AC stated the facilities previous AC should have used the R-FAA revised in 2019 for Resident 3, but they did not. During a concurrent interview and record review on 3/14/2025 at 10:20 a.m. with the Administrator (ADM), the ADM reviewed Resident 3's R-FAA revised 3/2007 and dated 11/14/2023, and a blank sample of the R-FAA revised 11/2019. The ADM stated the R-FAA is an alternative means to solve a problem and the R-FAA must comply with certain regulations. The ADM stated a key element of the R-FAA is to specifically indicate the selection of a neutral arbitrator and the selection of a venue that is convenient to both parties. The ADM stated the facility R-FAA was updated in 2019 to reflect these key elements. The ADM stated Resident 3's signed R-FAA did not include those key elements. The ADM stated when Resident 3's R-FAA did not specify a neutral party and convenient location, it could potentially result in placing the resident in a less favorable position than the facility during the arbitration process. During a follow-up concurrent interview and record review on 3/14/2025 at 1:19 p.m. with the ADM, the ADM reviewed the R-FAA revised 11/2019 and Information Regarding the Resident-Facility AA Form (AA Info. Form), undated. The ADM stated the facility does not have a policy regarding AAs. The ADM stated the facility uses the R-FAA revised 11/2019 and AA Info. Form to guide the arbitration agreement process. The ADM stated the facility process was not followed when Resident 3 entered into an R-FAA that did not provide for the selection of a neutral arbitrator agreed upon by both parties and for the selection of a venue that was convenient to both parties. During a review of the facility-provided AA Info. Form, undated, the AA Info. Form indicated a neutral arbitrator is a professional who is experienced in presiding over arbitration hearings. If the parties agree to arbitration, then the case will not be tried in court and there will be no jury. During a review of the facility-provided Resident - Facility AA, last revised 11/2019, the R-FAA indicated, . it is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration . Accordingly, this Agreement is to be governed by the Federal Arbitration Act and the procedural rules set forth in the Federal Arbitration Act (9 U.S.C. Sections 1-16) shall govern any petition to compel arbitration and the selection of an arbitrator, should the parties be unable to mutually agree upon the appoint of a single neutral arbitrator. The arbitration shall be venued in a location convenient for all parties .

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 38552 Based on interview and record review, the facility failed to ensure necessary care was provided consistently for a resident who was receiving hospice service (a program designed to provide a caring environment for meeting the physical and emotional needs of the terminally ill) for one of two sampled residents (Resident 95) reviewed under Hospice Care Area by, failing to: 1. Ensure the hospice doctor signed Resident 95's initial Certification of Terminal Illness (CTI-a document in which the physician certifies the patient is terminally ill with a prognosis of six (6) months or less). 2. Ensure Hospice Provider (HP) 1 provided Resident 95's hospice plan of care to the facility upon completion of the recertification of the resident's CTI. These deficient practices had the potential to negatively affect Resident 95's physical comfort, psychosocial well-being, and had the potential to result in a delay or a lack of necessary care and services. Findings: During a review of Resident 95's Admission Record, the Admission Record indicated the facility admitted the resident on 9/4/2024 with diagnoses including dementia (a progressive state of decline in mental abilities), generalized anxiety disorder (a mental health disorder that produces fear, worry, and a constant feeling of being overwhelmed), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 95's physician orders, dated 9/4/2024, the physician order indicated admit to the facility under services of HP 1 on routine level of care. During a review of Resident 95's History and Physical (H&P), dated 9/8/2024, the H&P indicated, the resident does not have the capacity to understand and make decisions. During a review of Resident 95's Minimum Data Set (MDS-a resident assessment tool), dated 12/17/2024, the MDS indicated the resident sometimes had the ability to understand others and make self understood. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/14/2025 at 9:57 a.m. with MDS Nurse (MDSN) 1, Resident 95's HP 1's plan of care and CTI from 9/4/2025 to 3/14/2025 were reviewed. MDSN 1 stated Resident 95's CTI, dated 2/28/2025, indicated a certification period from 3/3/2025 to 5/1/2025 did not have the resident's updated hospice plan of care that reflects the updated treatment. MDSN 1 stated the updated hospice plan of care should have been provided and filed on the resident's chart on 3/3/2025. MDSN 1 stated the initial CTI for period 9/4/2024 to 11/2/22024 did not have electronic signature and no wet signature. MDSN 1 stated it should have been signed by the hospice doctor when the resident was certified for terminal illness. MDSN 1 stated the reason for the hospice plan of care and the hospice combined is to keep the patient comfortable which has all the disciplines, has the diet, medications, and code status so they have a plan including pain management which should be in the plan of care. MDSN 1 stated not providing the updated hospice plan of care has the potential to result in a communication barrier between hospice and the facility. MDSN 1 stated they would not know what the updated treatment is, including how often, and which disciplines would see the resident the hospice is providing to the resident. During an interview on 3/14/2025 at 2:57 p.m. with the Director of Nursing (DON), the DON stated the hospice doctor should sign the CTI after they admitted the resident and the resident/representative had agreed to hospice care. The DON stated the CTI is to prove if the resident really needs to be on hospice and is terminally ill. The DON stated the hospice doctor signature is proof that he saw and assessed the resident and certified that the resident is terminally ill. The DON stated the hospice plan of care should be provided so they know how to take care of the resident and what they do with the resident. The DON stated the hospice plan of care will include the management of the resident's pain and discomfort. The DON stated the hospice plan of care should be provided immediately. During a review of the facility's policy and procedure (P&P) titled, Hospice Program, last reviewed 9/27/2024, the P&P indicated In order for a resident to qualify for the hospice benefit under Medicare, he or she must be . certified as being terminally ill . hospice providers who contract with this facility . are held responsible for meeting the same professional standards and timeliness of service as any contracted individual or agency associated with the facility . It is the responsibility of the hospice to manage the resident's care as it relates to the terminal illness and related conditions, including the following: a. Determining the appropriate hospice plan of care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 38552 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections by failing to ensure clean linens were protected from environmental contaminants when 17 of 17 clean linen cart covers were covered with a permeable (can be passed through, especially by liquids or gases)/loosely woven material to cover the linens. This deficient practice had the potential to spread infections and illnesses among residents and staff. Findings: During a concurrent observation and interview on 3/13/2025 at 9:01 a.m. with Certified Nursing Assistant (CNA) 7, CNA 7 stated each CNA has a clean linen cart and the blue cover is made of nesh and netted. CNA 7 stated the laundry staff disinfects the linen carts. During a concurrent interview and record review on 3/13/2025 at 1:36 p.m. with CNA 8, CNA 8 stated the clean linen cart covers have tiny holes. During a concurrent observation and interview on 3/14/2025 at 7:21 a.m. with Laundry Staff (LS) 1, while inside the laundry room, LS 1 stated they have a total of 17 clean linen carts. LS counted 16 clean linen carts inside the laundry room and the other cart inside the linen closet in nursing station 2. LS 1 stated she does not clean the linen carts it's the second shift, but they use the bleach wipes which they wipe it down and then dry. LS 1 stated once a week they hose it down. During a concurrent observation and interview on 3/14/2025 at 8:41 a.m. with the Infection Preventionist (IP) and the Housekeeping Supervisor (HSKS), while in the laundry room, the HKS stated the linen carts are disinfected at the end of every shift and every Thursday they do a pressure wash. The HKS stated the cover used in their linen carts are made of porous materials where air and water could pass through. The HKS stated dust particles could pass through their linen cart covers. The HKS stated they are in the process of changing the linen cart covers to a non-porous material which they order from an outside vendor. During an interview on 3/14/2025 at 8:51 a.m., the IP stated the clean linen carts should be covered with non-porous material. The IP stated there is a potential for contamination with dust and liquid, and this would affect the cleanliness of the linens. During an interview on 3/14/2025 at 3:04 p.m. with the Director of Nursing (DON), the DON stated they are ordering new linen cart covers. The DON stated they had used the same one since the last recertification survey visit 3/2024 and since she has been here at this facility. The DON stated it is important to make sure the clean linen cart covers do not have openings to make sure not to give dirty linens to residents and is part of their infection control. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the Linen Cart Cover 1's Manufacturer's Guidelines, dated 1/12/2017, the Manufacturer's Guidelines indicated the product day-to-day maintenance to follow: 1. Blot liquid spills with a clean, dry cloth. For oil-based spills, apply an absorbent such as corn starch, then remove with a straight edge. 2. Spray on a mild cleaning solution of soap and water. 3. Rinse the fabric thoroughly to remove all soap residue. 4. Air dry. The Manufacturer's Guidelines indicated to follow all safety and environmental precautions according to the bleach label and always rinse thoroughly with tepid water before allowing to air dry. During a review of the facility's Bleach Wipes 1's Safety Data Sheet (SDS), dated 11/22/2022, the SDS indicated recommended for use on hard, non-porous (not porous [material having pores or openings]) surfaces. During a review of the facility's policy and procedure (P&P) titled, Cleaning and Disinfection of Resident-Care Items and Equipment, last reviewed 9/27/2024, the P&P indicated the resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current Centers of Disease Control (CDC-a national public health agency in the United States) recommendations for disinfection and the Occupational Safety and Health Administration (OSHA-assures safe and healthful working conditions by setting and enforcing standards, and by providing training, outreach, education and assistance) Bloodborne Pathogens Standard. The P&P indicated semi-critical items consist of items that may come in contact with mucous membranes or non-intact skin such devices should be free from all microorganisms, although small numbers of bacterial spores are permissible. The P&P indicated reusable items are cleaned and disinfected or sterilized between residents according to manufacturer's instructions.