STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056351	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chatsworth Park Health Care Center	10610 Owensmouth Chatsworth, CA 91311

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38549 Based on interview and record review, the facility failed to rightfully inform in advance of the risks and benefits of the proposed plan in medication for two of eight sampled residents (Resident 106 and 56) by failing to: 1. Obtain an informed consent (a process in which patients are given important information, including possible risks and benefits, about a medical procedure or treatment) when Resident 106's Seroquel (antipsychotic- a medication used to treat psychosis [a mental condition in which thought, and emotions are so affected that contact is lost with external reality]) dosage was increased. This deficient practice violated the resident's and his/her representative's right to make an informed decision regarding the use of an antipsychotic medication. 2. Obtain an informed consent when Resident 56's Zyprexa (antipsychotic medication) dosage was increased. These deficient practices violated the resident's and his/her representative's right to make an informed decision regarding the use of an antipsychotic medication. Findings: a. A review of Resident 106's Admission Record indicated the facility admitted the resident on 12/25/2023 with diagnoses including dementia (decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities). A review of Resident 106's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 3/27/2024, indicated the resident had severely impaired cognition (the mental processes that take place in the brain) and required moderate assistance from staff for toileting hygiene and dressing. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/17/2024 at 4:11 p.m., with Minimum Data Set Nurse 1 (MDS Nurse 1), reviewed Resident 106's physician's orders. MDS Nurse 1 stated Resident 106 had a current active order for Seroquel 50 milligrams (mg - unit of measurement) every 12 hours for schizoaffective disorder (a mental health condition that includes features of both schizophrenia [serious mental illness that affects how a person thinks, feels, and behaves] and a mood disorder [marked disruptions in emotions]) manifested by calm to hostile behavior, sudden angry outburst. MDS Nurse 1 stated Resident 106's Seroquel was increased from 50 mg at bedtime to 50 mg every 12 hours, starting on 1/22/2024. MDS Nurse 1 stated that the only informed consent she could find in Resident 106's medical record was dated 12/28/2023 for Seroquel 50 mg at bedtime. MDS Nurse 1 stated there was no informed consent when the Seroquel increased in dosage. MDS Nurse 1 stated the facility should have obtained a new informed consent when the dosage was increased. During an interview on 4/18/2024 at 11:18 a.m., with the Director of Nursing (DON), the DON stated an informed consent was important because it made the resident/representative aware of any risks and side effects of the medication. The DON stated the facility should have obtained a new informed consent when Resident 106's Seroquel dosage was increased. The DON stated, by not obtaining a new informed consent, the resident's/representative's right to be informed of their medical treatment was violated. A review of the facility's policy and procedure titled, Psychotropic Medications, last reviewed on 12/2023, indicated that the facility's interdisciplinary team (IDT - a group of people from different disciplines or fields of knowledge who work together to address a common problem or goal) will review to ensure that an informed consent was obtained prior to medication use. 49252 b. A review of Resident 56's Admission Record indicated the facility admitted the resident on 11/2/2023 with diagnoses that included low back pain, dementia, and psychosis (a severe mental condition in which thought and emotions are so affected that contact is lost with external reality). A review of Resident 56's History and Physical (H&P- a term used to describe a physician's examination of a resident) dated 11/3/2023, indicated Resident 56 did not have the capacity to understand and make decisions. A review of Resident 56's MDS dated [DATE], indicated Resident 56 had moderately impaired cognition. A review of Resident 56's Order Summary Report, dated 11/25/2023, indicated a current order for Zyprexa oral tablet give 3.75 mg by mouth at bedtime for schizophrenia manifested by paranoia (persistent feeling that people are 'out to get you') that food is poison with a start date of 11/13/2023. A review of Resident 56's physician's orders, dated 11/13/2023 at 4:00 p.m., indicated a previous order of Zyprexa 2.5 mg by mouth at bedtime to be discontinued and to start and increased dose of Zyprexa 3.75 mg by mouth at bedtime for schizophrenia manifested by paranoia that her food was being poisoned. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/18/2024 at 4:49 p.m., with the Director of Nursing (DON), reviewed Resident 56's physician order for Zyprexa, dated 11/13/2023 with the Psychotherapeutic Medications - Facility Verification of Resident Informed Consent (FVRIC) dated 11/2/2023. The DON stated Resident 56's FVRIC indicated informed consent was last obtained verbally from Resident 56's representative on 11/2/2023 for Zyprexa 2.5mg. The DON stated when there's a change in order, the nurse needs to get another informed consent. The DON stated it is important to obtain informed consent because Zyprexa is an antipsychotic and sometimes there's a lot of side effects/adverse effects (undesired harmful effect resulting from a medication or other intervention) and these medications pose risk to the residents. The DON agreed and stated it is the resident's or resident's representative right to be fully informed in advance of their treatment. A review of the facility's policy and procedure titled, Psychotropic Medications, last revised on 12/2023, indicated, Informed consent was obtained prior to medication use and Upon change of condition or initiation of a new order for psychoactive medications, the facility will obtain consent prior to the initiation of the new medication.

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38549 Based on observation, interview, and record review, the facility failed to ensure that six of six residents (Residents 123, 102, 60, 32, 48, and 67) interviewed during the Resident Council Meeting (a group of nursing home residents who meet regularly to discuss their rights, quality of care, and quality of life) were aware of how to contact the State Survey Agency (the department) to file a complaint. This deficient practice had the potential to deprive the residents of assistance from resident advocacy groups should unresolved issues arise in the facility. Findings: A review of Resident 123's Admission Record indicated the facility originally admitted the resident on 5/24/2022 and readmitted the resident on 10/8/2023 with diagnoses including end stage renal disease (when the kidneys can no longer function on their own to meet the body's needs). A review of Resident 123's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 2/29/2024, indicated the resident severely impaired cognition (the mental thought process of acquiring knowledge and understanding through thought, experience, and the senses) and required maximum assistance from staff for toileting hygiene and dressing. A review of Resident 102's Admission Record indicated the facility admitted the resident on 3/22/2023 with diagnoses that included arthrogryposis multiplex congenita (term used to describes a variety of conditions involving multiple joint contractures [fixed tightening of muscle, tendons, joints, or other tissues or shorten causing a deformity]). A review of Resident 102's MDS, dated [DATE], indicated the resident had intact cognition and was dependent on staff for all activities of daily living (ADL- activities related to personal care). A review of Resident 60's Admission Record indicated the facility originally admitted the resident on 7/5/2023 and readmitted the resident on 1/23/2024 with diagnoses including unspecified open wound on the right knee. A review of Resident 60's MDS, dated [DATE], indicated the resident had intact cognition and required moderate assistance from staff for transfers. A review of Resident 32's Admission Record indicated the facility admitted the resident on 6/24/2023 with diagnoses including chronic obstructive pulmonary disease (COPD - group of lung diseases that cause breathing problems and restricted airflow). A review of Resident 32's MDS, dated [DATE], indicated the resident had intact cognition and was independent for most ADLs. A review of Resident 48's Admission Record indicated the facility originally admitted the resident on 11/13/2019 and readmitted the resident on 1/19/2024 with diagnoses including COPD. (continued on next page)

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 48's MDS, dated [DATE], indicated the resident had intact cognition and required moderate assistance from staff for toileting hygiene, dressing, and personal hygiene. A review of Resident 67's Admission Record indicated the facility admitted the resident on 9/20/2022 with diagnoses including type two (2) diabetes mellitus (a chronic condition that affects the way the body processes blood glucose [sugar]). A review of Resident 67's MDS, dated [DATE], indicated the resident had intact cognition and required supervision for most ADLs. During the Resident Council Meeting on 4/16/2024 at 1:58 p.m., Residents 123, 102, 60, 32, 48, and 67 stated they were not aware of how to file a complaint with the State Survey Agency. During a concurrent observation and interview on 4/16/2024 at 2:54 p.m., with the Administrator (ADM) and Director of Nursing (DON), observed where the posting was to contact the State Survey Agency. Both the ADM and DON agreed and stated that the print was too small, and it was placed too high on the consumer board (board that contains a list of names or numbers for pertinent list of state regulatory agencies and resident advocacy groups (group of people who are for the interest of residents in nursing homes). The ADM and DON stated that the posting should be more prominent and at eye level. A review of the facility's policy and procedure titled, Resident Rights and Responsibilities, Notice of, last reviewed on 1/11/2024, indicated that it is the policy of the facility to inform the resident both orally and in writing of their rights as a resident, as well as the rules and regulations governing the resident's conduct and responsibilities during their stay in the facility. To assure that the residents, staff, and visitors are continually informed and aware of resident rights, grievance procedures, and responsibilities, large print copies may be posted in a prominent area in the facility.

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49252 Based on interview and record review, the facility failed to protect a resident's right to be free from physical abuse (deliberately aggressive or violent behavior with the intention to cause harm) for one of three sampled residents (Resident 100) when on 4/7/2024, Resident 106 pulled the hair of Resident 100 causing Resident 100 to fall on the floor. This deficient practice resulted in Resident 100 being subjected to physical abuse by Resident 106 while under the care of the facility. Resident 100 sustained bleeding to the scalp (skin on top of a resident's head where hair grows) and pain to the left ankle. Findings: A review of Resident 100's Admission Record indicated Resident 100 was admitted to the facility on [DATE] with diagnoses that included a history of falling, difficulty in walking and hypertension (high blood pressure). A review of Resident 100's History and Physical (H&P- a term used to describe a physician's examination of a resident) dated 3/9/2023, indicated that Resident 100 had the capacity to understand and make decisions. A review of Resident 100's Minimum Data Set (MDS, a standardized resident assessment and care screening tool) dated 3/1/2024, indicated that Resident 100's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. A review of Resident 100's Change in Condition (COC - when there is a sudden change in a resident's health) Form dated 4/7/24 at 7:55 a.m., indicated another resident (Resident 106) pulled Resident 100's hair causing Resident 100 to sustain a fall. A review of Resident 100's Fall Committee Interdisciplinary Care Team (a group of health care professionals with various expertise who work together toward the goals of their residents) Note, dated 4/10/2024 at 9:59 p. m., indicated that on 4/7/2024 at around 7:55 a.m. Resident 106 went towards Resident 100, grabbed, and pulled Resident 100 by the hair causing Resident 100 to fall on the floor. The note further indicated that Resident 100 was noted with slight bleeding on the scalp caused by Resident 106's fingernails. The note indicated that Resident 100 complained of left ankle pain. A review of Resident 106's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included hyperlipidemia (having too many lipids [fats] in the blood) and dementia (progressive impaired ability to think, remember or make decisions that interferes with doing everyday activities). A review of Resident 106's MDS dated [DATE], indicated that Resident 106 had severely impaired cognition. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 106's COC Form dated 4/7/2024 at 7:55 a.m., indicated that Resident 106 pulled another resident's (Resident 100) hair causing Resident 100 to fall. During an interview with Licensed Vocational Nurse 2 (LVN 2) on 4/15/2024 at 3:45 p.m., LVN 2 stated that on the morning of 4/7/2024, Resident 106 pulled Resident 100 out of Resident 100's wheelchair. LVN 2 stated the interaction between the two residents was physical abuse, assault (physical attack). There was physical abuse and physical contact to the extent that the other one was harmed. During an interview with Registered Nurse 2 (RN 2) on 4/16/2024 at 8:48 a.m., RN 2 stated that on 4/7/2024, when Resident 106 pulled Resident 100's hair, Resident 106 was inflicting physical harm which was abuse, the aggressor (referring to Resident 106) physically abused the victim (referring to Resident 100). During an interview with Resident 100 on 4/16/2024 at 9:45 a.m., Resident 100 stated that on 4/7/2024, Resident 106 pulled her hair and pulled her out of her wheelchair onto the floor causing injuries to the left side of her head and left foot. Resident 100 stated she was shaken by the incident and that it was scary, causing Resident 100 to feel nervous about the incident. During an interview with Director of Nursing (DON) on 4/18/2024 at 4:34 p.m., the DON stated that the incident between Resident 106 and Resident 100 that occurred on 4/7/2024 at 7:55 a.m. could have possibly been prevented if facility staff had taken Resident 106 back to the resident's room. During an interview with the Administrator (ADM) on 4/19/2024 at 1:05 p.m., the ADM stated that Resident 106 pulling the hair of Resident 100 was deliberate. During an interview with the DON on 4/19/2024 at 1:05 p.m., the DON stated that Resident 106 pulling the hair of Resident 100 was deliberate. A review of the facility's policy and procedure titled Abuse: Prevention and Prohibition Against, last reviewed on 10/2022, indicated that each resident has the right to be free from abuse. The policy defines abuse as a willful (intentional) infliction of injury with resulting physical harm, pain, or mental anguish (suffering). The policy further indicated that willful means that the resident must have acted deliberately.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 48678 Based on interview and record review, the facility failed to develop a baseline care plan (a written document that summarizes a patient's needs, goals, and care) within 48 hours of admission for one of one sampled resident (Resident 378) who tested positive for coronavirus disease -2019 (COVID-19, a highly contagious viral infection that can trigger respiratory tract infection). This deficient practice had the potential to result in a negative impact on residents' health and safety, as well as the quality of care and services received. Findings: A review of Resident 378's Admission Record indicated the facility admitted the resident on 4/10/2024 with diagnosis including COVID-19. A review of Resident 378's History & Physical indicated Resident 378 had the capacity to understand and make decisions. A review of Resident 378's Order Summary Report dated 4/10/2024, indicated Resident 378 was on transmission-based precautions (steps taken to prevent spread of infection to others): respiratory (used for patients that have an infection that can be spread over long distances when suspended in the air), droplet (used to prevent the spread of pathogens that are passed through respiratory secretions), and contact precautions (intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the patient or the patient's environment). The Order Summary Report indicated Resident 378 should be in a single room in isolation until 4/17/2024. During an interview and record review on 4/15/2024 at 3:24 p.m., with Registered Nurse Supervisor (RN 1), reviewed Resident 378's care plans from 4/10/2024 to 4/15/2024. RN 1 stated there should be an initial/baseline care plan for treating Resident 378's COVID-19. RN 1 stated Resident 378 did not have a baseline care plan for COVID-19. RN 1 stated it is important to have a care plan in place so that everyone follows the isolation precautions. RN 1 stated no care plan was initiated for Resident 378's diagnosis of COVID-19 48 hours after admission. A review of the facility's policy and procedure titled, Comprehensive Person-Centered Care Planning, dated 12/2023, indicated, the interdisciplinary team (IDT, a group of health care professionals with various areas of expertise who work together toward the goals of the residents' care plan) will develop and implement a baseline care plan for each resident, within 48 hours of admission that includes minimum healthcare information necessary to properly care for each resident and instructions needed to provide effective and person-centered care that meet professional standards of quality of care including, but not limited to: Initial goals based on admission orders Physician orders (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dietary orders Therapy services.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 42275 Based on interview and record review, the facility failed to develop a comprehensive person-centered care plan (a plan for a resident's specific health needs and desired health outcomes) related to constipation (a bowel dysfunction that makes bowel movements [BM] infrequent or hard to pass) for one of four sampled residents (Resident 408); when Resident 408 was first identified as being at risk for constipation on 5/19/2024. This deficient practice had the potential to result in failure to deliver necessary care and services. Findings: A review of Resident 408's Admission Record indicated the facility initially admitted the resident on 11/30/2023 and readmitted the resident on 5/19/2024 with diagnoses including right hip dislocation (bones in the hip being pushed out of their usual place) and osteoarthritis (a condition that causes joints to become painful and stiff). A review of Resident 408's Minimum Data Set (MDS - a standardized assessment and screening tool) dated 3/6/2024, indicated Resident 408's cognition (ability to think and make decisions) was intact. The MDS further indicated Resident 408 was dependent on staff for toileting hygiene, showering. The MDS indicated that Resident 408 needed extensive assistance from staff for mobility (movement) such as rolling from side to side in the bed, lying to sitting on side of bed, and sitting to standing. A review of Resident 408's Physician Order dated 5/19/202,4 indicated to give polyethylene glycol 3350 powder (medication to treat constipation) 17 gram (g - a unit of measurement) by mouth one time a day for BM, hold if loose BM (when your stools are loose and watery). A review of Resident 408's care plan titled At risk for constipation related to decrease mobility, opioid use (a class of pain medication) indicated an imitated date of 6/6/2024. During a concurrent interview and record review on 6/6/2024 at 11 a.m. with the Assistant Director of Nursing (ADON), reviewed Resident 408's care plans from 11/30/2023 to 6/6/2024. ADON stated that the facility did not develop a care plan for Resident 408's constipation until the morning of 6/6/2024. During an interview with the ADON on 6/6/2024 at 12:13 p.m., the ADON stated that the facility should have immediately developed a comprehensive person-centered care plans for Resident 408's constipation with the goal that Resident 408 will have regular bowel movements when the resident was first identified as being at risk for constipation on 5/19/2024. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Comprehensive Person-Centered Care Planning, last reviewed on 1/11/2024, indicated, It is the policy of this facility that the interdisciplinary team (IDT-team members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and the timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment .

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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** 48142 Based on interview and record review, the facility failed to provide care in accordance with professional standards by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (beneath the skin) administration sites of insulin (a hormone that lowers the level of sugar in the blood) for one of two sampled residents (Resident 69) investigated under insulin. The deficient practice had the potential for adverse effects (undesired harmful effect resulting from a medication or other intervention) of same site subcutaneous administration of insulin such as lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (a rare disease that occurs when a protein called amyloid builds up in organs). Findings: A review of Resident 69's Admission Record indicated the facility admitted the resident on 6/11/2023 with diagnoses including type two (2) diabetes mellitus (a chronic condition that affects the way the body processes blood glucose [sugar]) and heart failure (the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen). A review of Resident 69's History and Physical (H&P- a term used to describe a physician's examination of a resident) dated 6/15/2023, indicated the resident had the capacity to understand and make decisions. A review of Resident 69's Order Summary Report indicated the following orders: - Insulin glargine (long acting insulin) solution 100 unit/milliliter (unit/ml, a unit of measurement) inject 5 unit subcutaneously one time a day for diabetes, ordered on 6/11/2023. - Insulin lispro (rapid acting insulin) injection solution inject as per sliding scale (progressive increase in the insulin dosage, based on pre-defined blood glucose ranges): if 71-150 = 0 unit: 151-200 = 0 unit; 201-250 = 1 unit; 251-300 = 2 units; 301-350= 3 units; 351-400 = 4 units; [PHONE NUMBER] = 5 units > 400 call physician, subcutaneously at bedtime for diabetes mellitus, ordered on 6/11/2023. - Insulin lispro injection solution inject as per sliding scale: if 71-150 = 0 unit; 151-200 =1 unit; 201-250 = 2 units; 251-300 = 3 units; 301-350 = 4 units; 351-400 = 6 units; [PHONE NUMBER] = 8 units >400 call physician, subcutaneously before meals for diabetes mellitus, ordered on 6/11/2023. - Insulin lispro subcutaneous solution cartridge 100 unit/ml inject six (6) unit subcutaneously with meals for diabetes mellitus, ordered on 6/11/2023. A review of Resident 69's Location of Administration Record dated 4/1/2024 to 4/17/2024, indicated insulin administered on the following dates: - On 4/1/2024 at 6:33 a.m., insulin lispro was administered on the right arm. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chatsworth Park Health Care Center	10610 Owensmouth Chatsworth, CA 91311

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 4/1/2024 at 5:18 p.m., insulin lispro was administered on the right arm. - On 4/1/2024 at 8:21 p.m., insulin lispro was administered on the right arm. - On 4/2/2024 at 9:02 a.m., insulin glargine was administered on the right arm. - On 4/2/2024 at 11:55 a.m., insulin lispro was administered on the right arm. - On 4/4/2024 at 6:41 p.m., insulin lispro was administered on the left lower quadrant of the abdomen. - On 4/5/2024 at 6:51 a.m., insulin lispro was administered on the left lower quadrant of the abdomen. - On 4/5/2024 at 9:30 a.m., insulin glargine was administered on the right arm. - On 4/5/2024 at 10:57 a.m., insulin lispro was administered on the right arm. - On 4/5/2024 at 2:57 p.m., insulin lispro was administered on the right arm. - On 4/5/2024 at 6:13 p.m., insulin lispro was administered on the right arm. - On 4/6/2024 at 7:17 a.m., insulin lispro was administered on the right arm. - On 4/6/2024 at 9:12 a.m., insulin glargine was administered on the right arm. - On 4/6/2024 at 11:42 a.m., insulin lispro was administered on the right arm. - On 4/6/2024 at 6:21 p.m., insulin lispro was administered on the left arm. - On 4/7/2024 at 6:33 a.m., insulin lispro was administered on the left arm. - On 4/7/2024 at 9:45 a.m., insulin glargine was administered on the right arm. - On 4/7/2024 at 11:40 a.m., insulin lispro was administered on the right arm. - On 4/7/2024 at 4:14 p.m., insulin lispro was administered on the right arm. - On 4/8/2024 at 6:06 a.m., insulin lispro was administered on the right arm. - On 4/8/2024 at 9:35 a.m., insulin glargine was administered on the right arm. - On 4/8/2024 at 11:53 a.m., insulin lispro was administered on the right arm. - On 4/8/2024 at 12:54 p.m., insulin lispro was administered on the right arm. - On 4/9/2024 at 9:44 a.m., insulin glargine was administered on the right arm. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 4/10/2024 at 8:19 a.m., insulin glargine was administered on the right arm. - On 4/11/2024 at 9:36 a.m., insulin glargine was administered on the right arm. - On 4/12/2024 at 8:54 a.m., insulin glargine was administered on the right arm. - On 4/13/2024 at 9:18 a.m., insulin glargine was administered on the right arm. - On 4/13/2024 at 9:47 p.m., insulin lispro was administered on the right arm. - On 4/14/2024 at 8:28 a.m., insulin glargine was administered on the right arm. - On 4/14/2024 at 11:35 a.m., insulin lispro was administered on the right arm. - On 4/15/2024 at 10:31 a.m., insulin glargine was administered on the right arm. - On 4/15/2024 at 10:42 a.m., insulin lispro was administered on the right arm. - On 4/15/2024 at 4:24 p.m., insulin lispro was administered on the right arm. - On 4/16/2024 at 8:27 a.m., insulin glargine was administered on the right arm. - On 4/16/2024 at 11:01 a.m., insulin lispro was administered on the right arm. - On 4/16/2024 at 4:30 p.m., insulin lispro was administered on the right arm. During an interview and record review on 4/17/2024 at 2:16 p.m., with Registered Nurse 1 (RN 1), reviewed Resident 69's Location of Administration Record dated 4/1/2024 to 4/17/2024. RN 1 stated the licensed nurses were not rotating the administration site for insulin. RN 1 stated they should rotate the injection site to prevent skin irritation. A review of the facility's policy and procedure titled, Diabetic Management, last reviewed on 1/11/2024, indicated for insulin dependent and long-acting insulin to rotate injection site and document.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48142 Based on observation, interview, and record review the facility failed to ensure that a medicine cup of diclofenac sodium gel (gel used to relieve pain) was not left at the bedside table of one of three sampled residents (Resident 330). This deficient practice had the potential to place residents at risk for theft and loss of medication and increased risk for drug overdose and or medication errors. Findings: A review of Resident 330's Admission Record indicated the facility admitted the resident on 4/5/2024 with diagnosis of wedge compression fracture (small breaks or cracks) of second lumbar vertebra (second bone in the lumbar spine). A review of Resident 330's History and Physical Examination (H&P- a term used to describe a physician's examination of a resident) dated 4/7/2024, indicated the resident had the capacity to make decisions. A review of Resident 330's physician's orders dated 4/13/2024, indicated an order for diclofenac sodium external gel 1% apply to affected area topically four times a day for pain management. During a concurrent observation and interview on 4/15/2024 at 10:28 a.m., with Restorative Nurse Assistant (RNA 1), observed in Resident 330's room a medicine cup with white color cream inside on Resident 330's bedside table. RNA 1 was asked what was the white cream and RNA 1 stated they didn't know. During a concurrent observation and interview on 4/15/2024 at 10:33 a.m., with the Director of Nursing (DON), in Resident 330's room, observed a medicine cup with a white color cream. When the DON was asked what the cream on Resident 330's bedside table was, the DON did not respond and grabbed the cream instead and ask Registered Nurse (RN 1) to find out what the cream was and who left it there at the bedside. During a concurrent interview and record review on 4/15/2024 at 10:38 a.m., with RN 1 and License Vocational Nurse (LVN 5), when asked by RN 1 if LVN 5 knew who left the medication at Resident 330's bedside table and what kind of medication it is, LVN 5 stated it's Resident 330's cream for pain and already saw it at Resident 330's bedside table during the morning medication pass. RN 1 stated that was not the right practice and LVN 5 should have removed the medication when they found it because other residents can take it and could have an adverse effect (undesired effect). Reviewed Resident 330's physician's order and RN 1 confirmed by stating that Resident 330 had an order for diclofenac sodium gel order to apply in affected area four times a day for pain management. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/15/2024 at 11:18 a.m., with LVN 5, when asked if LVN 5 usually leaves medication at bedside, LVN 5 stated she does not leave medication at bedside and already saw the medication at bedside this morning when she gave medication to Resident 330. LVN 5 further stated that medication should not be left at bedside because another resident can take it. During a concurrent interview and record review on 4/17/2024 at 9:33 a.m., with RN 1, reviewed Resident 330's assessments from 4/5/2024 to 4/17/2024. When asked if Resident 330 has an assessment for self-administering of medication, RN 1 stated there was no assessment found. RN 1 stated an assessment must be done first before allowing the resident to self-administer a medication to determine if the resident is capable of self-administering the medication. RN 1 further stated Resident 330 might not take it properly or might overdose and could possibly lead to harm. A review of the facility's policy and procedure titled, Self-administering of Medications, last reviewed on 1/11/2024, indicated that if the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive (including orientation to time), physical, and visual ability to carry out this responsibility during the care planning process.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 49252 Based on interview and record review, the facility failed to the facility failed to ensure effective pain management was done by failing to administer pain medication for the appropriate pain scale as indicated by the physician's orders for one of two sampled residents (Resident 100). This deficient practice had the potential to result in confusion on the delivery of care and services rendered and may lead to inadequate management of residents' pain. Findings: A review of Resident 100's Admission Record indicated the facility admitted the resident on 3/4/2023 with diagnoses that included a history of falling, difficulty in walking, and hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]). A review of Resident 100's History and Physical (H&P- a term used to describe a physician's examination of a resident) dated 3/9/2023, indicated, Resident 100 had the capacity to understand and make decisions. A review of Resident 100's Minimum Data Set (MDS, a standardized resident assessment and care screening tool) dated 3/1/2024, indicated Resident 100's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. A review of Resident 100's Medication Administration Record (MAR), dated 4/1/2024 to 4/30/2024, indicated, acetaminophen oral tablet 500 milligram (mg- a unit of measurement) by mouth every six hours as needed for mild pain severity 1-3/10 (on a pain rating scale of zero being no pain, and 10 being the worst possible pain, severe pain is rated as 10 on a 1-10 scale) and acetaminophen two tablets 325 mg by mouth every six hours as needed for moderate pain severity 4-6/10. The MAR indicated an administration of acetaminophen tablet 500 mg by mouth for a pain level of 1-3 was administered on 4/7/2024 at 8:00 a.m. for a pain level of 5/10 by Licensed Vocational Nurse 2 (LVN 2). A review of Resident 100's electronic Medication Administration Record (eMAR) Administration Note, dated 4/7/2024 at 8:00 a.m., indicated Resident 100 complained of five (5) out of 10 left ankle pain and LVN 2 gave 1 tablet of acetaminophen 500 mg by mouth that was ordered for pain levels of 1-3. During a concurrent interview and record review on 4/18/2024 at 4:55 p.m., with the Director of Nursing (DON), reviewed Resident 100's MAR, dated 4/2024. The Don stated the MAR indicated that on 4/7/2024 at 8:00 a.m., Resident 100 had a pain level of 5 and received an acetaminophen 500 mg tablet by mouth to be given for pain of 1-3 by LVN 2. The DON stated it was not appropriate for the nurse to give that dose for a pain level of 5. The DON stated the nurse should have followed the orders and given the acetaminophen order for the correct pain scale. A review of the facility's policy and procedure titled, Pain Recognition and Management, revised 12/2023, indicated, To ensure that pain management is provided to residents who require such services, consistent with professional standards of practice .pain will be identified using a scale of 1-10 . (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Administration of Medication, dated 12/2023, indicated, It is the policy of this Facility, medication shall be administered as prescribed by the resident's physician, nurse practitioner, or physician's assistant.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 48142 Based on interview and record review, the facility failed to complete a post-hemodialysis (HD, the removing of waste and excess fluid to prevent build up in the body for residents who have loss of kidney [organs that remove waste products from the blood and produce urine] function) assessment for one of two sampled residents (Resident 38) investigated addressing the dialysis care area. This deficient practice placed Resident 38 at risk for complications of dialysis such as redness at the dialysis access site (way to reach the blood for hemodialysis), edema (too much fluid trapped in the body's tissues), excessive bleeding, and a change in vital signs (clinical measurements that indicate the state of a patient's essential body functions). Findings: A review of Resident 38's Admission Record indicated the facility admitted the resident on 3/21/2023 and readmitted the resident on 3/1/2024 with diagnosis that included dysphagia (difficulty swallowing) and end stage renal disease (a condition in which the kidneys no longer function normally). A review of Resident 38's History and Physical (H&P- a term used to describe a physician's examination of a resident) dated 3/18/2024, indicated the resident does not have the capacity to understand and make decisions. A review of Resident 38's physician's orders dated 3/13/2024, indicated an order for dialysis 3 time a week every Tuesday, Thursday, Saturday. A review of Resident 38's Nurse's Dialysis Communication Record Book, dated 4/16/2024, indicated the post-dialysis assessment was blank and there was no documentation for post-hemodialysis monitoring for an assessment of the access site and vital signs. During a concurrent interview and record review on 4/17/2024 at 2:25 p.m., with Registered Nurse (RN 1), reviewed Resident 38's Nurse's Dialysis Communication Record Book dated 4/16/2024. RN 1 confirmed by stating that the post assessment sheet was blank, and it was supposed to filled out. RN 1 stated the resident is to be assessed after dialysis treatment to monitor the resident's vital signs and access site for bleeding. RN 1 also stated the form was blank, which meant it was not done. A review of the facility's policy and procedure titled, Dialysis (Renal) Pre- and Post Care, last reviewed on 1/11/2024, indicated: Documentation related to pre- and post-dialysis care will be placed in the clinical record and include: Resident assessments, interventions, and any provided education. Assessment of renal dialysis access site, to include presence or absence and quality of a bruit (sound of blood passing through the access site) and thrill (vibration of blood passing through the access site) for residents with an arteriovenous fistula (abnormal connection between an artery and a vein).

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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** 34659 Based on observation, interview, and record review, the facility failed to: 1. Ensure one of one sampled resident (Resident 67) received morning medications scheduled for 9 a.m. on time and not given at 11:15 a.m. These deficient practices resulted in the omission of medications, receiving medications before they are due, or giving medications after they are due which could have resulted in severe health complications. 2. Ensure the Controlled Drug Record (CDR- accountability record of medications that are considered to have a strong potential for abuse) coincided with the Medication Administration Records (MAR) for two of five sampled residents (Resident 44 and 48). These deficient practices had the potential to result in medication error and/or drug diversion (illegal distribution or abuse of prescription drug). Findings: 1. A review of Resident 67's Admission Record indicated the facility admitted the resident on 9/20/2022 with diagnoses that included hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]), atrial fibrillation (an irregular and often very rapid heart rhythm), and depression (mood disorder that causes a persistent feeling of sadness and loss of interest). A review of Resident 67's MDS dated [DATE], indicated Resident 67 was cognitively intact with skills required for daily decision making. The MDS indicated Resident 67 was independent with eating and moderate assistance (helper does less than half the effort) with dressing and personal hygiene. A review of Resident 67's physician's orders indicated the following: - Advair-Diskus (a medication given to help a resident breathe) aerosol powder breath activated 100-50 micrograms per dose (mcg/dose, a unit of measurement), one inhalation, inhale by mouth in the morning for wheezing (breathing with a whistling or rattling sound in the chest)/shortness of breath, ordered 2/15/2024. - Dicyclomine hydrochloride (medication used to treat irritable bowel syndrome [disorder that causes uncomfortable abdominal symptoms]) oral capsule 10 mg, give one capsule by mouth one time a day for irritable bowel syndrome, dated 1/19/2024. - Lasix tablet (medication given to reduce swelling in the arms and legs) 20 mg, give 20 mg by mouth one time a day for swelling, dated 1/19/2024. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Multi-Vitamin/Minerals tablet, give one tablet by mouth one time a day for supplement, dated 1/19/2024. - Potassium chloride extended release tablet (a medication given to increase potassium) 10 milliequivalents (mEq, a unit of measurement), give one tablet by mouth one time a day for use of Lasix, dated 1/19/2024. - Prednisone tablet 20 mg (a medication used to treat many conditions with inflammation), give one tablet by mouth one time a day for cough and congestion, dated 1/22/2024. - Primidone tablet (a medication to prevent seizures [sudden, uncontrolled body movements and changes in behavior that occur because of abnormal electrical activity in the brain]), give 75 mg by mouth one time a day for seizures, dated 1/22/2024. - Prostat (liquid protein medical food) 30 milliliters (ml, a unit of measurement) by mouth one time a day for supplement, dated 1/22/2024. - Calcium citrate + vitamin D tablet 315-200 mg unit, give one tablet by mouth two times a day for supplement to meet calcium needs, dated 4/5/2024. - Duloxetine hydrochloride capsule (a medication to treat depression) 30 mg, give one capsule by mouth two times a day for depression, manifested by verbalization of feeling sad, dated 1/19/2024. - Sotalol HCl tablet (a medication given for high blood pressure), give one tablet by mouth two times a day for hypertension, hold for systolic blood pressure (SBP - the first number in a blood pressure reading, which measures the pressure in the arteries [pathway that carries blood away from the heart] when the heart beats) less than 110 millimeters of mercury (mmHg, a unit of measure), dated 1/19/2024. - Gabapentin capsule (a medication to treat neuropathy [weakness, numbness, and pain from nerve damage, usually in the hands and feet]), give 1000 mg by mouth three times a day for neuropathy, dated 2/22/2024. During an interview on 4/18/2024 at 11 a.m., with Resident 67, Resident 67 stated she had not received her 9 a.m. medications yet. During an observation and interview on 4/18/2024 at 11:15 a.m., with LVN 6, observed LVN 6 give Resident 67 her 9 a.m. medications. LVN 6 stated those medications were given late. LVN 6 stated she will notify Resident 67's physician that the medications were given late. A review of Resident 67's Nursing Progress Notes, dated 4/18/2024 at 2:28 p.m., indicated Resident 67's physician was called and notified that Resident 67 received their medications late and received order to give 5 p.m. medications at 7 p.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure titled, Administration of Drugs/Treatments, last reviewed 1/11/2024, indicated medications and treatments must be administered in accordance with the written orders of the attending physician. The policy and procedure indicated the nurse administering the medication must initial the resident's electronic MAR, on the appropriate line and date for that specific day following six (6) rights of medication administration which includes the right time. The policy and procedure indicated the right time is the prescribed time frame. The policy and procedure indicated medications must be administered within one (1) hour before or after their prescribed time. 2.a. A review of Resident 44's Admission Record indicated the facility admitted the resident on 9/17/2021 with diagnoses that included multiple fractures of ribs and right side. A review of Resident 44's MDS dated [DATE], indicated Resident 44 was cognitively intact with skills required for daily decision making. The MDS indicated Resident 44 was independent with eating and maximum assistance (helper does more than half the effort) with dressing. A review of Resident 44's physician's orders indicated an order for tramadol (medication used for moderate to severe pain) 50 mg tablet, take one tablet by mouth every six hours as needed for severe pain 7-10/10 pain scale, dated 4/4/2024. A review of Resident 44's Care Plan for Pain, initiated 4/1/2024, indicated a goal that the resident will verbalize adequate relief of pain through the review date. The care plan indicated an intervention to give pain medication as ordered. A review of Resident 44's CDR indicated the following times tramadol was removed from the medication cart: - 4/2/2024 at 5 a.m. - 4/10/2024 at 11 a.m. - 4/12/2024 at 9 p.m. A review of Resident 44's MAR dated 4/2024, indicated tramadol was not documented on 4/2/2024 at 5 a.m., 4/10/2024 at 11 a.m., and 4/12/2024 at 9 p.m. During a concurrent interview and record review on 4/16/2024 at 4 p.m., with LVN 5, reviewed Resident 44's CDR for tramadol and MAR dated 4/2024. LVN 5 stated the CDR for tramadol did not match the corresponding MAR. LVN 5 stated the licensed nurse should have signed Resident 44's MAR after giving the medication on 4/2/2024 at 5 a.m., 4/10/2024 at 11 a.m., and 4/12/2024 at 9 p.m. During a concurrent interview and record review on 4/18/2024 at 8:15 a.m., with the Director of Nursing (DON), reviewed Resident 44's CDR for tramadol and MAR dated 4/2024. The DON stated the process for administering a controlled drug to a resident is to remove the medication from the package, sign out the medication on the CDR, administer the medication to the resident, and then sign the MAR. The DON stated this is important to keep an accurate count of the medication and to prevent drug diversion. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.b. A review of Resident 48's Admission Record indicated the facility admitted the resident on 11/13/2019 and readmitted the resident on 1/19/2024 with diagnoses that included multiple fractures of ribs and right side. A review of Resident 48's MDS dated [DATE], indicated Resident 48 was cognitively intact with skills required for daily decision making. The MDS indicated Resident 48 was independent with eating and moderate assistance with dressing and personal hygiene. A review of Resident 48's physician's orders indicated an order for oxycodone (medication used for moderate and severe pain) tablet five (5) mg, give one tablet by mouth every four hours as needed for breakthrough pain (severe pain occurring after a patient was medicated with a long-acting pain medication), dated 1/26/2024. A review of Resident 48's CDR indicated oxycodone was removed from the medication cart for the following dates and times: - 4/1/2024 at 1:40 a.m. - 4/2/2024 at 5:40 p.m. - 4/3/2024 at 9 a.m. - 4/4/2024 at 11 a.m. - 4/7/2024 at 7 p.m. - 4/10/2024 at 9 a.m. - 4/11/2024 at 9 a.m. - 4/13/2024 at 10:30 a.m. - 4/13/2024 at 6 p.m. A review of Resident 48's MAR dated 4/2024, indicated there was no documentation for the above dates and times. During a concurrent interview and record review on 4/16/2024 at 4 p.m., with LVN 5, reviewed Resident 48's CDR for oxycodone and MAR dated 4/2024. LVN 5 stated the CDR for oxycodone did not match the corresponding MAR. LVN 5 stated the licensed nurse should have signed Resident 48's MAR after giving the medication on 4/1/2024 at 1:40 a.m., 4/2/2024 at 5:40 p.m., 4/3/2024 at 9 a.m., 4/4/2024 at 11 a.m., 4/7/2024 at 7 p.m., 4/10/2024 at 9 a.m., 4/11/2024 at 9 a.m., 4/13/2024 at 10:30 a.m., and 4/13/2024 at 6 p.m. (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 concurrent interview and record review on 4/18/2024 at 8:15 a.m., with the DON), reviewed Resident 48's CDR for oxycodone and [DATE]/2024. The DON stated the process for administering a controlled drug to a resident is to remove the medication from the package, sign out the medication on the CDR, administer the medication to the resident and to then sign the MAR. The DON stated this is important to keep an accurate count of the medication and to prevent drug diversion. A review of the facility's policy and procedure titled, Administration of Drugs/Treatments, last reviewed 1/11/2024, indicated the nurse administering the medications must initial the resident's eMAR, on the appropriate line and date for that specific day following six rights of medication administration: right resident, right time, right medication, right dose, right route, and right documentation. The policy and procedure indicated right documentation, as to document administration after the administration of the medication. A review of the facility's policy and procedure titled, Controlled Medications - Storage and Reconciliation, last reviewed 1/11/2024, indicated when a controlled medication is administered, the licensed nurse administering the medication immediately enters all of the following information on the accountability record: date and time of administration, amount administered, signature of the nurse administering the dose, completed after the medication is actually administered.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 34659 Based on interview and record review, the facility failed to ensure the Medication Regimen Review (MRR - review of a resident's drug therapy to assure appropriateness of medication usage completed each month by the consultant pharmacist) was acted upon for one of five residents (Resident 67) by failing to act upon the facility consultant pharmacist's recommendation for Resident 67's prednisone (a medication used to treat many conditions associated with inflammation) to give with food. This deficient practice has placed the resident at an increased risk of experiencing adverse side effects (unwanted undesirable effects that are possibly related to a drug) and had the potential for the resident to experience stomach irritation. Findings: A review of Resident 67's Admission Record indicated the facility admitted the resident on 9/20/2022 with diagnoses that included gastroesophageal reflux disease (GERD, stomach contents flow backward, up into the esophagus, the tube that carries food from your throat into stomach). A review of Resident 67's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 3/20/2024, indicated Resident 67 was cognitively (the process of acquiring knowledge and understanding through thought, experience, and the senses) intact with skills required for daily decision making. The MDS indicated Resident 67 was independent with eating and moderate assistance (helper does less than half the effort) with dressing and personal hygiene. A review of Resident 67's physician's orders indicated an order for prednisone tablet 20 milligram (mg, a unit of measurement) give one tablet by mouth one time a day for cough and congestion, dated 1/22/2024. A review of Resident 67's Consultant Pharmacist's MRR dated 3/9/2024, indicated a recommendation to add Take with Food, to the prednisone order. During a concurrent interview and record review on 4/18/2024 at 11:35 a.m., with the Assistant Director of Nursing (ADON), reviewed Resident 67's MRR dated 3/9/2024 and Physician's Order Summary dated 3/9/2024. The ADON stated the licensed nurses did not follow the consultant pharmacist's recommendation to add Take with Food, to the prednisone order. The ADON stated it is important to follow the consultant pharmacist's order so that Resident 67 will not have any stomach irritation or issues. The ADON stated if the recommendation is not added to the order, then the licensed nurse giving the medication will not know to give the prednisone with food. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/19/2024 at 9:12 a.m., with the ADON, reviewed the facility's policy and procedure titled, Consultant Pharmacist Reports, last reviewed 1/11/2024. The ADON stated, once receiving the MRR from the consultant pharmacist, the recommendations are reviewed, the doctor is notified and if the doctor agrees with the recommendation, he will change the order to reflect what the consultant pharmacist recommends. The ADON stated the licensed nurses are to conduct this process and is to be completed within 30 days from the date the recommendation is received. The ADON referred to the phrase within 30 days, as to the time frame in which the facility is to review and respond to the MRR. A review of the facility's policy and procedure titled, Consultant Pharmacist Reports, last reviewed 1/11/2024, indicated the following: Recommendations concerning medication therapy are communicated in a timely fashion. The timing of these recommendations should enable a response prior to the next medication regimen review. In the event of a problem requiring the immediate attention of the prescriber, the responsible prescriber or physician's designee is contacted by the consultant pharmacist or the facility, and the prescriber response is documented on the consultant pharmacist review record or elsewhere in the resident's record. Recommendations are acted upon and documented by the facility staff and/or the prescriber. If the prescriber does not respond to [the] recommendation directed to him/her [within 30 days], the Director of Nursing (DON) and/or the consultant pharmacist may contact the Medical Director (the physician responsible for the overall care and clinical practice caried out in the facility). A review of the facility's resource titled, Prednisone Tablets, issued 3/6/2024, indicated to take prednisone with food or milk.

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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** 49252 Based on interview and record review, the facility failed to: 1. Ensure psychotropic drugs (any medication capable of affecting the mind, emotions, and behavior) were not used unnecessarily for one of six sampled residents (Resident 56) when receiving a duplicate therapy of Zyprexa (antipsychotic- a medication used to treat psychosis [a mental condition in which thought, and emotions are so affected that contact is lost with external reality]) at nighttime for 41 days. 2. Address a resident's behavior of physical/verbal aggression due to complaints of her room being too cold with non-pharmacological interventions (non-invasive actions that can prevent, treat, or cure health problems without medication) prior to administering as needed (prn) haloperidol (antipsychotic medication) for one (Resident 106) out of six sampled residents investigated under the care area of unnecessary medications. 3. Ensure that the administration of prn lorazepam (medication used to treat anxiety [intense, excessive, and persistent worry and fear about everyday situations]) coincided with and was accurately reflected in the behavioral monitoring for one (Resident 57) out of six sampled residents investigated under the care area of unnecessary medications. 4. Provide non-pharmacological interventions prior to administering prn lorazepam for one (Resident 57) out of six sampled residents investigated under the care area of unnecessary medications. These deficient practices resulted in the use of unnecessary psychotropic drugs for the residents and had the potential to lead to side effects and adverse consequences (undesired harmful effect resulting from a medication or other intervention), such as a decline in quality of life and functional capacity. Findings: 1. A review of Resident 56's Admission Record indicated the facility admitted the resident on 11/2/2023 with diagnoses that included low back pain, dementia (progressive impaired ability to think, remember or make decisions that interferes with doing everyday activities), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with external reality). A review of Resident 56's History and Physical (H&P- a term used to describe a physician's examination of a resident) dated 11/3/2023, indicated Resident 56 did not have the capacity to understand and make decisions. A review of Resident 56's Minimum Data Set (MDS, a standardized resident assessment and care screening tool) dated 2/6/2024, indicated Resident 56 had moderately impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 56's physician's order, dated 11/13/2023 at 4:00 p.m., indicated a previous order of Zyprexa (olanzapine - generic name) 2.5 milligrams (mg, a unit of measurement) by mouth at bedtime to be discontinued and to start an increased dose of Zyprexa 3.75 mg by mouth at bedtime to treat schizophrenia (mental disorder in which people interpret reality abnormally) manifested by paranoia (persistent feeling that people are 'out to get you') that her food was being poisoned. A review of Resident 56's Order Summary Report, dated 11/25/2023, indicated a current order for Zyprexa oral tablet, give 3.75 by mouth at bedtime for schizophrenia manifested by paranoia that food is poison with a start date of 11/13/2023. During a concurrent interview and record review on 4/18/2024 at 4:49 p.m., with the Director of Nursing (DON), reviewed Resident 56's Medication Administration Record (MAR - report that serves as a legal record of the drugs administered to a patient at a facility by a healthcare professional) for 11/2023 and 12/2023. The MAR indicated Resident 56's Zyprexa 2.5 mg tablet was not discontinued as ordered on 11/13/2023 and was given nightly to Resident 56 along with the new order of Zyprexa 3.75 mg until 12/25/2023. The DON stated Zyprexa 2.5 mg dose should have been discontinued as ordered. The DON acknowledged by stating Resident 56 received duplicate medication therapy for 41 days and that it could cause Resident 56 to become altered (change in mental function) because of an overdose of medications and should have been verified by the nurses. A review of the facility's policy and procedure titled, Administration of Medication, dated 12/2023, indicated, Medications must be administered in accordance with the written orders of the attending physician. A review of the facility's policy and procedure titled, Administration of Drugs/Treatments, revised 1/2024, indicated, the nurse administering the medications must follow the six rights of medication administration and give the Right Medication by checking medications against the order before they are given. 38549 2. A review of Resident 106's Admission Record indicated the facility admitted the resident on 12/25/2023 with diagnoses including a history of falling and dementia. A review of Resident 106's MDS dated [DATE], indicated the resident had severely impaired cognition (the mental processes that take place in the brain, including thinking, attention, language, learning, memory, and perception) and required moderate assistance from staff for toileting hygiene and dressing. A review of Resident 106's physician's orders indicated an order for haloperidol two (2) mg intramuscularly (IM - administered into a muscle) every six (6) hours as needed for agitation manifested by physical and verbal aggression for 14 days, ordered on 3/12/2024. A review of Resident 106's nursing progress note, dated 3/15/2024, indicated the nurse administered haloperidol to the resident for an episode of physical and verbal aggression due to the resident complaining that her room was cold. (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 4/16/2024 at 11:45 a.m., with the Maintenance Director (MD), reviewed the Maintenance Log (document that records maintenance activities performed). MD stated he could not find any documentation in his Maintenance Log that Resident 106's complaints about her room being cold was relayed to him in the month of 3/2024. During a concurrent interview and record review on 4/17/2024 at 4:25 p.m., with Minimum Data Set Nurse 1 (MDS Nurse 1), reviewed Resident 106's nursing progress notes and 3/2024 MAR. MDS Nurse 1 verified by stating that on 3/15/2024 at 9:40 p.m., the nurse administered haloperidol to Resident 106 for an episode of physical and verbal aggression due to the resident complaining that her room was cold. MDS Nurse 1 stated that prior to administering the medication, the nurse should have attempted to give Resident 106 an extra blanket or asked Maintenance to turn the temperature up in the room. MDS Nurse 1 stated those non-pharmacological interventions could possibly have calmed Resident 106 down. During an interview on 4/18/2024 at 11:18 a.m., with the Director of Nursing (DON), the DON stated that non-pharmacological interventions should be attempted prior to giving the resident prn psychotropic medications (drugs that affect the mind, emotions, and behaviors) because the resident may not need the medication after all. The DON stated we do not want to give the resident unnecessary medications because it increases his/her risk of experiencing side effects. The DON stated the resident's behavior can possibly be diverted without the use of medications. A review of the facility's policy and procedure titled, Psychotropic Medications, last reviewed on 12/2023, indicated that residents who use psychotropic drugs receive gradual dose reductions (GDR - the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose of a medication), and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Psychotropic medications shall not be administered for the purpose of discipline or convenience. They are to be administered only when required to treat the resident's medical symptoms and will be considered only after nonpharmacological interventions have been attempted and failed. 3. A review of Resident 57's Admission Record indicated the facility originally admitted the resident on 4/28/2018 and readmitted the resident on 12/6/2020 with diagnoses including schizoaffective disorder (a mental health condition that includes features of both schizophrenia [serious mental illness that affects how a person thinks, feels, and behaves] and a mood disorder [marked disruptions in emotions]) and bipolar disorder (mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks). A review of Resident 57's MDS dated [DATE], indicated the resident had intact cognition and required supervision for most activities of daily living (ADL- activities related to personal care). A review of Resident 57's physician's order indicated the following: - Lorazepam 0.5 mg by mouth every six (6) hours as needed for anxiety manifested by panic attacks for 14 days, ordered on 3/26/2024. - Lorazepam 0.25 mg by mouth every 6 hours as needed for anxiety manifested by panic attacks for 14 days, ordered on 4/10/2024. (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 4/18/2024 at 10:33 a.m., with Minimum Data Set Nurse 2 (MDS Nurse 2), reviewed Resident 57's MAR dated 4/2024. MDS Nurse 2 stated Resident 57 received prn lorazepam every day from 4/1/2024 - 4/13/2024 on almost every shift. MDS Nurse 2 stated that the behavioral monitoring for lorazepam in 4/2024 indicated that Resident 57 had two behavioral episodes for that month. MDS Nurse 2 stated that if the nurse is administering lorazepam for an exhibited behavior, then that behavior should be tallied. MDS Nurse 2 stated it was important to accurately document the number of behaviors the resident is actually having so that the psychiatrist can appropriately order a GDR. During an interview on 4/18/2024 at 11:18 a.m., the DON stated that the number of behavioral episodes should accurately reflect the administration of prn lorazepam. The DON stated it was important for the doctor to be able to determine if the medication can be reduced or if the resident really needs the medication. A review of the facility's policy and procedure titled, Psychotropic Medications, last reviewed on 12/2023, indicated that the facility's Interdisciplinary Team (IDT - a group of professionals from different disciplines who work together to achieve a common goal) will review to ensure psychotropic medications are not given in excessive dosage. 4. A review of Resident 57's Admission Record indicated the facility originally admitted the resident on 4/28/2018 and readmitted the resident on 12/6/2020 with diagnoses including schizoaffective disorder and bipolar disorder. A review of Resident 57's MDS, dated [DATE], indicated the resident had intact cognition and required supervision for most ADLs. A review of Resident 57's physician's order indicated the following: - Lorazepam 0.5 mg by mouth every 6 hours as needed for anxiety manifested by panic attacks for 14 days, ordered on 3/26/2024. - Lorazepam 0.25 mg by mouth every 6 hours as needed for anxiety manifested by panic attacks for 14 days, ordered on 4/10/2024. During a concurrent interview and record review on 4/18/2024 at 10:33 a.m., with MDS Nurse 2, reviewed Resident 57's MAR dated 4/2024. MDS Nurse 2 stated Resident 57 received prn lorazepam every day from 4/1/2024 - 4/13/2024 on almost every shift. MDS Nurse 2 stated she could not find any documentation indicating that non-pharmacological interventions were attempted prior to administering the medication to Resident 57. During an interview on 4/18/2024 at 11:18 a.m., with the DON, the DON stated that non-pharmacological interventions should be attempted prior to giving the resident prn psychotropic medications because the resident may not need the medication after all. The DON stated we do not want to give the resident unnecessary medications because it increases his/her risk of experiencing side effects. The DON stated the resident's behavior can possibly be diverted without the use of medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure titled, Psychotropic Medications, last reviewed on 12/2023, indicated that residents who use psychotropic drugs receive gradual dose reductions (GDR - the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose of a medication), and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Psychotropic medications shall not be administered for the purpose of discipline or convenience. They are to be administered only when required to treat the resident's medical symptoms and will be considered only after nonpharmacological interventions have been attempted and failed.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 34659 Based on observation, interview, and record review, the facility failed to ensure residents were free from any significant medication errors for one of five sampled residents (Resident 67) by failing to ensure Licensed Vocational Nurse 6 (LVN 6) checked Resident 67's blood pressure before giving a blood pressure medication. This deficient practice had the potential to cause complications such as low blood pressure, resulting in hospitalization . Findings: A review of Resident 67's Admission Record indicated the facility admitted the resident on 9/20/2022 with diagnoses that included hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]), atrial fibrillation (an irregular and often very rapid heart rhythm), and depression (mood disorder that causes a persistent feeling of sadness and loss of interest). A review of Resident 67's Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 3/20/2024, indicated Resident 67 was cognitively (the mental processes that take place in the brain) intact with skills required for daily decision making. The MDS indicated Resident 67 was independent with eating and moderate assistance (helper does less than half the effort) with dressing and personal hygiene. A review of Resident 67's physician's orders indicated an order for Sotalol hydrochloride tablet (a medication given for high blood pressure), give one tablet by mouth two times a day for hypertension, hold for systolic blood pressure (SBP - the first number in a blood pressure reading, which measures the pressure in the arteries [pathway that carries blood away from the heart] when the heart beats) less than 110 millimeters of mercury (mmHg, a unit of measurement), dated 1/19/2024. During an interview on 4/18/2024 at 11 a.m., with Resident 67, Resident 67 stated she had not received her 9 a.m. medications yet. During an observation and interview on 4/18/2024 at 11:15 a.m., with LVN 6, went to Resident 67's room and observed LVN 6 in the room giving Resident 67 her 9 a.m. medications which included Sotalol. When LVN 6 exited the room, LVN 6 was asked what Resident 67's blood pressure was and she stated a certified nursing assistant took the blood pressure earlier in the morning but was unable to state when that was or what the blood pressure reading was. LVN 6 stated, I should take the blood pressure, and went back into the room and took Resident 67's blood pressure which was 111/86 mmHg. During an interview on 4/18/2024 at 4:03 p.m., with the Director of Nursing (DON), the DON stated LVN 6 should have taken Resident 67's blood pressure before giving the Sotalol medication. The DON stated this was important so that Resident 67 would not experience adverse side effects (undesired harmful effect resulting from a medication or other intervention) such as hypotension (low blood pressure) which could result in dizziness and fainting. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's drug reference for Sotalol, issued 4/3/2024, indicated to check blood pressure and heart rate as the doctor has told you. A review of the facility's policy and procedure titled, Administration of Drugs/Treatments, last reviewed 1/11/2024, indicated medications must be administered in accordance with the written orders of the attending physician.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38549 Based on observation, interview, and record review, the facility failed to: 1. Label one of two sampled resident's (Resident 48) opened package of albuterol sulfate (relaxes muscles in the airways to increase air flow to the lungs) vials with the date it was opened. 2. Label one of two sampled resident's (Resident 44) opened package of ipratropium bromide and albuterol sulfate (Duoneb - relaxes muscles in the airways to increase air flow to the lungs) with the date it was opened. These deficient practices had the potential to compromise the therapeutic effectiveness of the stored medications given to the residents because of inappropriate storage of the medications. 3. Discard a discontinued vial of Haldol (antipsychotic- a medication used to treat psychosis [a mental condition in which thought, and emotions are so affected that contact is lost with external reality]) for one of one sampled resident (Resident 106). This deficient practice had the potential to place the facility at potential for inability to readily identify loss and drug diversion (illegal distribution of abuse of prescription drugs or their use for unintended purposes) of controlled medications. Findings: 1. A review of Resident 48's Admission Record indicated the facility originally admitted the resident on 11/13/2019 and readmitted the resident on 1/19/2024 with diagnoses including chronic obstructive pulmonary disease (COPD - a group of lung diseases that cause breathing problems and restricted airflow). A review of Resident 48's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 2/12/2024, indicated the resident had intact cognition (the mental process of acquiring knowledge and understanding through thought, experience, and the senses) and required moderate assistance from staff for toileting hygiene, dressing, and personal hygiene. During a concurrent observation and interview on 4/16/2024 at 4 p.m., with Licensed Vocational Nurse 5 (LVN 5), observed the contents of Medication Cart A. Observed an opened package of albuterol sulfate breathing treatments for Resident 48 that was not labeled with an open date. LVN 5 stated it should have been labeled with an open date. During an interview on 4/19/2024 at 10 a.m., with the Assistant Director of Nursing (ADON), the ADON stated it should have been labeled with an open date. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure titled, Medication Storage in the Facility, last reviewed on 1/11/2024, indicated that medications in multi-dose packaging will have beyond-use dating of 60 days or manufacturer's expiration date if less than 60 days. 2. A review of Resident 44's Admission Record indicated the facility originally admitted the resident on 9/17/2021 and readmitted the resident on 11/5/2021 with diagnoses including atrial fibrillation (a type of irregular heartbeat). A review of Resident 44's MDS, dated [DATE], indicated the resident had intact cognition and required maximum assistance from staff for most activities of daily living (ADLs - the basic skills needed to live independently). During a concurrent observation and interview on 4/16/2024 at 4 p.m., with LVN 5, observed the contents of Medication Cart A. Observed an opened package of ipratropium bromide and albuterol sulfate breathing treatments for Resident 44 that was not labeled with an open date. LVN 5 stated it should have been labeled with an open date. During an interview on 4/19/2024 at 10 a.m., with the ADON, the ADON stated it should have been labeled with an open date. A review of the facility's policy and procedure titled, Medication Storage in the Facility, last reviewed on 1/11/2024, indicated that medications in multi-dose packaging will have beyond-use dating of 60 days or manufacturer's expiration date if less than 60 days. 49252 3. A review of Resident 106's Admission Record indicated the facility admitted the resident on 12/25/2023 with diagnoses that included hyperlipidemia (abnormally high concentration of fats in the blood), dementia (progressive impaired ability to think, remember or make decisions that interferes with doing everyday activities), and difficulty in walking. A review of Resident 106's MDS dated [DATE], indicated Resident 106 had severely impaired cognition. A review of Resident 106's Change in Condition Evaluation, dated 4/7/2024 at 7:55 a.m., indicated the resident was verbally and physically aggressive and Resident 106's primary physician renewed Resident 106's previous Haldol order. A review of Resident 106's discontinued physician orders indicated the last order for Haldol injection solution for agitation manifested by physical and verbal aggression was ordered on 3/12/2024 for 14 days. During an interview on 4/15/2024 at 3:45 p.m., with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated the medical intervention for Resident 106 on 4/7/2024 was a Haldol injection that was obtained from a leftover vial from a previous incident and remained in Medication Cart B. LVN 2 stated that if the Haldol order was current, the vial should be kept in the medication cart, but the order was discontinued on 3/26/2024. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Emergency Kit (e-kit- basic emergency medical kit that includes common emergency drugs) Pharmacy Log for 4/2024, indicated no records of Haldol being retrieved for Resident 106. A review of the facility's policy and procedure titled, Disposal of Medications and Medication-Related Supplies, dated 8/2019, indicated When medications are discontinued by a prescriber .the medications are marked as discontinued and destroyed .Medications are removed from the medication cart immediately upon receipt of an order to discontinue (to avoid inadvertent administration). Medications awaiting disposal or return are stored in a locked secured area designated for that purpose until destroyed or picked up by the pharmacy.

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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. 38549 Based on observation, interview, and record review, the facility failed to follow proper food handling practices by failing to ensure that food found inside a refrigerator designated for residents were labeled with the date they were placed in the refrigerator. This deficient practice had the potential to place 111 out of 117 residents living in the facility at risk for foodborne illnesses (refers to illness caused by the ingestion of contaminated food or beverages). Findings: During a concurrent observation and interview on 4/15/2024 at 8:57 a.m., with the Dietary Supervisor (DS), observed a refrigerator designated for residents who bring in food from the outside. The following were found inside the refrigerator: - An undated container of chicken and rice. - An undated bag with pickled vegetables. - An undated container of rice. The DS stated the food will have to be discarded, since they were not labeled with the date they were brought in. The DS stated the food cannot be in the refrigerator for more than 72 hours to ensure safety from foodborne pathogens. During an interview on 4/18/2024 at 11:18 a.m., with the Director of Nursing (DON), the DON stated it was important to label food inside the resident refrigerator with the date it was put in there to ensure the food was not spoiled. The DON stated residents can get a foodborne illness if they consume food that is spoiled. A review of the facility's policy and procedure titled, Bringing in Food for a Resident, last reviewed on 1/11/2024, indicated that food or beverages should be labeled and dated to monitor for food safety.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34659 Based on interview and record review, the facility failed to maintain complete and accurate medical records for one of four sampled residents (Resident 12) by failing to document wound care treatments conducted on Resident 12 in Resident 12's Treatment Records (TAR, a legal document indicating the dates a treatment was conducted for a resident) for 1/2024. This deficient practice had the potential to result in confusion regarding Resident 12's condition and what care and services were provided to Resident 12. Findings: A review of Resident 12's Face Sheet indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dysphagia (difficulty swallowing) and a gastrostomy tube (G-tube, a plastic tube inserted into one's stomach to administer medications and nutrition for those having trouble with swallowing). A review of Resident 12' s Minimum Data Set (MDS - an assessment and screening too), dated 2/06/2024, indicated Resident 12 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 12 was dependent (helper does all the effort) on staff for personal hygiene and dressing. A review of Resident 12's Physician's Orders indicated the following: - Cleanse G-tube with normal saline (salty cleansing solution), pat dry, and apply split dressing (a dressing with a slit placed on the dressing to allow the G-tube to fit inside the dressing), every day shift (7 a.m. to 3:30 p.m.), dated 11/07/2022. - Left elbow skin tear (opening in the skin), cleanse with normal saline, pat dry, and apply xeroform (a type of dressing) and cover with foam dressing (dressing with foam) every day shift for skin management for 14 days, dated 1/27/2024. - Low air loss mattress (LALM-a special mattress to prevent and treat pressure ulcers [an open wound over a bone such as the tail bone]) for wound management, set per resident's weight or comfort every shift, dated 11/14/2022. A review of Resident 12's TAR for 1/2024 indicated the following dates without documentation: 1/14/2024 1/15/2024 1/19/2024 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/21/2024 1/22/2024 1/28/2024 1/29/2024 1/31/2024 During an interview and concurrent record review with Licensed Vocational Nurse 8 (LVN 8) on 4/17/2024 at 11:11 a.m., reviewed Resident 12's 1/2024 TAR. LVN 8 stated that there was a total of eight entries for Resident 12's 1/2024 TAR without documentation. During an interview with the Director of Nurses (DON) on 4/18/2024, DON stated the licensed nurses should be documenting in a resident's TAR each time treatment is conducted. A review of the facility's policy and procedure titled, Charting and Documentation, last reviewed 1/11/2024, indicated treatments and services performed with be documented in a resident's medical record.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 48142 Based on observation, interview, and record review, the facility failed to meet the required room size of 80 square feet (sq ft - unit of measurement) per resident for six of 59 multiple resident rooms (Rooms 108, 109, 208, 209, 215, and 216). This deficient practice had the potential to result in inadequate space to provide safe nursing care and privacy for the residents. Findings: During the Resident Council meeting (a group of nursing home residents who meet regularly to discuss their rights, quality of care, and quality of life) on 4/16/2024 at 2:00 p.m., when the residents were asked about their room space, there was no concerns or issues brought up. During the recertification survey from 4/15/2024 to 4/19/2024, observed that the residents residing in the rooms with an application for variance had sufficient amount of space for residents to move freely inside the rooms. There was adequate room for the operation and use of wheelchairs, walkers, and canes. The room variance did not affect the care and services provided by nursing staff to the residents. On 4/15/2024, the Administrator (ADM) submitted the Client Accommodation Analysis and a letter requesting for continuation of their room waiver. A review of the Client Accommodation Analysis indicated that six out of 59 resident rooms did not have at least 80 square feet per resident. The room waiver request and Client Accommodation Analysis showed the following: Room No. Square Footage Bed Capacity Sq. Ft. per Resident 108 158.4 2 75 109 158.4 2 76 208 158.4 2 79.65 209 146.52 2 77.79 215 146.4 2 77.67 216 155.89 2 78.01 The minimum requirement for a 2-bedroom should be at least 160 sq. ft. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	A review of the room waiver letter, undated, indicated, All patients in these rooms are not hindered or affected by the size of the patient's rooms and have mobility with walkers and/or wheelchairs. All of the basic furnishings are available to each patient and they have sufficient closet, drawer and storage spaces. Bathrooms are easily accessible to all patients. The rooms are close to the nursing station and exit doors. This makes it accessible to the evacuation area. These rooms are very well aerated and lighted. A denial of this waiver would cause a severe financial hardship which may affect the continued operation of the facility. After careful evaluation of the facility's building plan, the management has reached the conclusion that the waiver on room size will not in any way jeopardize the health and safety of the patients. The rooms are in accordance with the special needs of the resident and will not have an adverse effect on the residents health and safety or impede the ability of any resident in the room to attain his/her highest practicable well being.