STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056365	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yucaipa Hills Post Acute	13542 Second St. Yucaipa, CA 92399

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40171 Based on observation, interview, and record review, the facility failed to ensure one of eighteen residents (Resident 36) reviewed for advanced directives had a Physician Orders for Life Sustaining Treatment (POLST - written medical orders that addresses a limited number of critical medical decisions) accurately completed when there was conflicting information documented regarding medical interventions. This failure had the potential for Resident 36 to receive end of life care not in accordance with their wishes and for life sustaining measures to be rendered against what the resident wanted. Findings: During a review of Resident 36's Admission Record, (contains medical and demographic information), the Admission Record indicated Resident 36 was initially admitted to the facility on [DATE], with diagnoses which included hemiplegia and hemiparesis (weakness and paralysis on one side of the body) affecting left non-dominant side, heart failure, chronic respiratory failure (a long-term condition that prevents the body from exchanging oxygen and carbon dioxide properly), and Chronic Obstructive Pulmonary Disease (COPD - lung disease that causes breathing problems and restricted airflow). During a review of Resident 36's POLST, signed by a clinician on [DATE], the POLST indicated in Section A, Attempt Resuscitation/CPR [cardiopulmonary resuscitation - an emergency lifesaving procedure performed when the heart stops beating] . further review of Section A indicated, .selecting CPR in Section A requires selecting Full Treatment in Section B) .Section B of the POLST Medical Interventions, indicated two options; the first option was full treatment - Primary goal of prolonging life by all medically effective means .use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated . The second option was Selective Treatment - goal of treating medical conditions while avoiding burdensome measures .do not intubate .generally avoid intensive care . Of the two options, Selective Treatment was checked instead of Full Treatment as specified in Section A if Attempt/Resuscitation/CPR was selected. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview, and record review on [DATE], at 7:30 AM, with the Director of Nursing (DON), the DON stated if a resident wishes to have CPR/attempt resuscitation indicated in Section A of the POLST, then Section B must have full treatment checked as indicated on the instructions of the form. Resident 36's POLST was reviewed and the DON confirmed Attempt Resuscitation/CPR was checked in Section A and Section B had Selective Treatment selected. The DON stated Resident 36's POLST form needed to be clarified with the nurse who completed it. The DON further stated the POLST was supposed to be reviewed quarterly and upon admit for accuracy and completeness. The DON stated the POLST forms were important because it provides orders regarding what life sustaining treatments the resident desires. During an interview on [DATE], at 9:47 AM, with the Social Services Director (SSD), the SSD stated she was the one that completed the POLST for Resident 36, dated [DATE]. The SSD further stated she had the POLST revised by a physician today because it was not completed correctly. States the physician discussed with her the correct way to complete the POLST. During a review of the facility's policy and procedure (P&P) titled, Physician Orders for Life Sustaining Treatment (POLST), dated [DATE], the policy indicated, The physician Orders for Life-Sustaining Treatment (POLST) is a physician order form that complements an advance directive by converting an individual's wishes regarding life-sustaining treatment and resuscitation into physician orders. It is designed to be a statewide mechanism for an individual to communicate his or her wishes about a range of life-sustaining and resuscitative measures. It is designed to be portable, authoritative and immediately actionable physician order consistent with the individual's wishes and medical condition, which shall be honored across treatment settings .Completion of a POLST form should reflect a process of careful decision-making by the resident, or if the resident lacks decision-making capacity the resident's legally recognized health care decision maker, in consultation with the physician, about the resident's medical condition and known treatment preferences . Reviewing/Revising the POLST. 1. The POLST will be reviewed by the facility interdisciplinary team during the quarterly care planning conference .

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40171 Based on interview, and record review, the facility failed to ensure staff reported an allegation of abuse to the required parties and in the timelines specified by the facility's policy and procedures (P&P) and as required by federal regulations. This failure resulted in an allegation of abuse to not be reported and subsequently investigated which had the potential to place Residents 36 at risk for ongoing abuse or mistreatment due to a delay in the reporting and investigation of the alleged incident. Findings: A review of Resident 36's Admission Record (contains medical and demographic information), indicated Resident 36 was initially admitted to the facility on [DATE], with diagnoses which included hemiplegia and hemiparesis (weakness and paralysis) affecting left non-dominant side, heart failure, major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and anxiety disorder (a condition that causes excessive feelings of fear, dread, and worry that can interfere with daily life). During a concurrent observation and interview on October 14, 2024, at 3:00 PM, with Resident 36, Resident 36 was in her bed and was watching TV. Resident 36 stated staff would sometimes tell her she uses her call light too much and would take her call light away from her and put it where she couldn't see it or access it. During an interview on October 14, 2024, at 3:03 PM, with Resident 46 (roommate of Resident 36), Resident 46 stated she had seen staff tell Resident 36 that she uses the call light too much and take her call light away. During an interview on October 14, 2024, at 3:28 PM, with the Administrator (ADMIN), the ADMIN was informed by a surveyor regarding the allegation of abuse made by Resident 36. During an interview on October 17, 2024, at 6:41 PM, with Certified Nursing Assistant 6 (CNA 6), CNA 6 stated Resident 36 uses her call light ten to fifteen times throughout a shift and usually requires a lot of attention. CNA 6 further stated although she has not heard of Resident 36 having her call light taken away, she has heard of other residents who have told her that they had their call light taken away from them too. CNA 6 then stated she had informed her supervisor regarding the incident but could not remember who she informed. During an interview on October 17, 2024, at 7:06 PM, with Certified Nursing Assistant 7 (CNA 7), CNA 7 stated a resident had informed her in May of 2024, that a Certified Nursing Assistant working in the facility would take the residents call light away from them if the resident used the call light too much. CNA 7 stated she never reported the incident to anyone and only recalled mentioning it to another staff member but could not remember who. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on October 18, 2024, at 9:22 AM, with the ADMIN, the ADMIN stated he was the facility's abuse prevention coordinator and has been so since July 1, 2021. The ADMIN further stated he had never in the past been informed of facility staff allegedly taking call lights away from residents. The ADMIN stated if staff suspected abuse or were made aware of an abuse allegation, they were supposed to report it to him immediately. During a review of the facility's P&P titled, Abuse Investigation and Reporting, (undated), the policy indicated, All reports of abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management .Reporting .1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility administrator, or his/her designee, to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman; c. The resident's representative .d. law enforcement officials; e. The residents attending physician; and f. the facility medical director. 2. An alleged violation of abuse, neglect, exploitation or mistreatment will be reported immediately but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24 hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury .

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40171 Based on interview, and record review, the facility failed to ensure a Minimum Data Set (MDS- a facility assessment tool that consists of the resident assessment instrument (RAI) and the care area assessment (CAA) was conducted and submitted to the Centers of Medicare and Medicaid Services (CMS) in accordance with federal submission timeframes, for thirteen of thirteen residents (Residents 54, 55, 15, 27, 35, 40, 47, 49, 51, 62, 63, 66, and 76) reviewed for residents' assessment. These failures resulted in inadequate monitoring of progress or decline for Residents 54, 55, 15, 27, 35, 40, 47, 49, 51, 62, 63, 66, and 76 and the lack of resident specific information to CMS for payment and quality measure monitoring. Findings: A. During a review of Resident 54's Admission Record, (contains demographic and medical information), the Admission Record, indicated Resident 54 was admitted to the facility on [DATE], with diagnoses which included dementia (a progressive state of decline in mental abilities), psychosis (a mental disorder characterized by a disconnection from reality), major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest), and hypertension (high blood pressure). During a review of Resident 54's Electronic Health Record (EHR), a quarterly MDS assessment with an ARD (specific end point of look-back periods in the MDS assessment process) date of September 7, 2024, indicated it was completed on October 10, 2024 (33 days past the ARD). During a concurrent interview and record review on October 17, 2024, at 9:47 AM, with the Resource MDS Nurse (RMN), Resident 54's MDS assessment dated [DATE], was reviewed. The RMN stated the quarterly MDS assessment dated [DATE], was supposed to be completed within 14 days of September 7, 2024, but it was not completed until October 10, 2024. The RMN further stated he did not know why it was completed late. During an interview on October 17, 2024, at 9:52 AM, with the Director of Nursing (DON), the DON stated MDS assessments were supposed to be done on time but the facility had been having difficulties filling the MDS nurse (a nurse whose primary responsibility is to perform MDS assessments and related tasks) position because the previous MDS nurse left the company and the new MDS nurse is on leave. B. During a review of Resident 55's Admission Record, the Admission Record, indicated Resident 55 was admitted to the facility on [DATE], with diagnoses which included schizophrenia (a mental illness that is characterized by disturbances in thought), anxiety disorder (a condition that causes excessive worry and fear that can interfere with daily life), major depressive disorder and Chronic Obstructive Pulmonary Disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 55's Electronic Health Record (EHR), an MDS assessment with an ARD (specific end point of look-back periods in the MDS assessment process) date of September 7, 2024, indicated it was completed on October 11, 2024 (34 days past the ARD). (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on October 17, 2024, at 9:45 AM, with the RMN, Resident 55's MDS assessment dated [DATE], was reviewed. The RMN stated the quarterly MDS assessment dated [DATE], was supposed to be completed within 14 days of September 7, 2024, but it was not completed until October 11, 2024. The RMN further stated he did not know why it was completed late. 50575 C. During a review of Resident 27's Admission Record, the Admission Record indicated Resident 27 was admitted to the facility on [DATE], with diagnoses which included dementia (a progressive state of decline in mental abilities), and cerebral ischemia (occurs when the brain doesn't receive enough blood flow or oxygen). During an interview with Resource MDS Nurse (RMN), on October 17, 2024, at 10:22 AM, RMN stated that current Minimum Data Set Nurse (MDS- a facility assessment tool that consists of the resident assessment instrument (RAI) and the care area assessment (CAA) is out of the country due to a family emergency. RMN checked Resident 27's quarterly assessment that was done on August and MDS was transmitted for completion on October 10, 2024. He stated that he does not know why it was not turned in on time. During a continued interview and record review with RMN on October 17, 2024, at 11:25 AM, a clinical record titled, Centers for Medicare and Medicaid Services (CMS) Submission Report, for Resident 27 was reviewed. MDS quarterly assessment record and Assessment Reference Date (ARD- specific end point of look-back periods in the MDS assessment process) date was on August 19, 2024, but it was completed on October 10,2024, which was 52 days past the ARD. He stated that he does not know why it was not turned in on time. D. During a review of Resident 15's Admission Record, the Admission Record indicated Resident 15 was admitted to the facility on [DATE], with diagnoses which included (diabetes (condition that happens when your blood sugar is too high), hypertensive heart disease (problems with your heart that can develop if you have high blood pressure), and osteoarthritis (a chronic degenerative joint disease that occurs when the cartilage in a joint break down and becomes rough). During a concurrent interview and record review on October 17, 2024, at 11:53 AM, with RMN, Resident 15's clinical record titled, Centers for Medicare and Medicaid Services (CMS) Submission Report, was reviewed. Resident 15's MDS quarterly assessment record and (ARD) was on September 9, 2024, but it was completed on October 12,2024, which was 33 days past the ARD. He stated that he does not know why it was not turned in on time. E. During a review of Resident 35's Admission Record, the Admission Record indicated Resident 35 was admitted to the facility on [DATE], with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD- a chronic lung disease causing difficulty in breathing), dementia (a progressive state of decline in mental abilities), atherosclerosis of aorta (condition where plaque builds up in the walls of the aorta, the body's largest artery), and anxiety disorder (a condition that causes excessive worry and fear that can interfere with daily life). (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on October 17. 2024, at 11:53 AM, with RMN, Resident 35's clinical record titled, Centers for Medicare and Medicaid Services (CMS) Submission Report, was reviewed. Resident 35's MDS quarterly assessment record and ARD was on September 9, 2024, but it was completed on October 14,2024, which was 35 days past the ARD. He stated that he does not know why it was not turned in on time. F. During a review of Resident 40's Admission Record, the Admission Record indicated Resident 40 was admitted to the facility on [DATE], with diagnoses which included Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), chronic respiratory failure (a long-term condition that makes it difficult for the body to exchange oxygen), major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest), and epilepsy (a disorder of the brain characterized by repeated seizures). During a concurrent interview and record review on October 17,2024, at 11:53 AM, with RMN, Resident 40's clinical record titled, Centers for Medicare and Medicaid Services (CMS) Submission Report, was reviewed. Resident 40's MDS quarterly assessment record and ARD was on September 6, 2024, but it was completed on October 12,2024, which was 36 days past the ARD. He stated that he does not know why it was not turned in on time. G. During a review of Resident 47's Admission Record, the Admission Record indicated Resident 47 was admitted to the facility on [DATE], with diagnoses which included dementia (a progressive state of decline in mental abilities), chronic respiratory failure (condition where there's not enough oxygen or too much carbon dioxide in your body), hypertensive heart disease (problems with your heart that can develop if you have high blood pressure), and anxiety disorder (a condition that causes excessive worry and fear that can interfere with daily life). During a concurrent interview and record review on October 17, 2024, at 11:53 AM, with RMN, Resident 47's clinical record titled, Centers for Medicare and Medicaid Services (CMS) Submission Report, was reviewed. Resident 47's MDS quarterly assessment record ARD was on September 6, 2024, but it was completed on October 12,2024, which was 36 days past the ARD. He stated that he does not know why it was not turned in on time. H. During a review of Resident 49's Admission Record, the Admission Record indicated Resident 49 was admitted to the facility on [DATE], with diagnoses which included atherosclerotic heart disease (a condition where plaque builds up in the arteries of the heart), hypertensive heart disease (problems with your heart that can develop if you have high blood pressure), dementia (a progressive state of decline in mental abilities), and anxiety disorder (a condition that causes excessive worry and fear that can interfere with daily life). During a concurrent interview and record review on October 17, 2024, at 11:53 AM, with RMN, Resident 49's clinical record titled, Centers for Medicare and Medicaid Services (CMS) Submission Report, was reviewed. Resident 49's MDS quarterly assessment record and ARD was on August 30, 2024, but it was completed on October 12,2024, which was 43 days past the ARD. He stated that he does not know why it was not turned in on time. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	I. During a review of Resident 51's Admission Record, the Admission Record indicated Resident 51 was admitted to the facility on [DATE], with diagnoses which included dementia (a progressive state of decline in mental abilities), chronic respiratory failure (condition where there's not enough oxygen or too much carbon dioxide in your body), and major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest). During a concurrent interview and record review on October 17, 2024, at 11: 53 AM, with RMN, Resident 51's clinical record titled, Centers for Medicare and Medicaid Services (CMS) Submission Report, was reviewed. Resident 51's MDS quarterly assessment record and ARD was on September 6, 2024, but it was completed on October 12,2024, which was 36 days past the ARD. He stated that he does not know why it was not turned in on time. J. During a review of Resident 62's Admission Record, the Admission Record indicated Resident 62 was admitted to the facility on [DATE], with diagnoses which included Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), dementia (a progressive state of decline in mental abilities), and diabetes (condition that happens when your blood sugar is too high). During a concurrent interview and record review on October 17, 2024, at 11:53 AM, with RMN, Resident 62's clinical record titled, Centers for Medicare and Medicaid Services (CMS) Submission Report, was reviewed. Resident 62's MDS quarterly assessment record and ARD was on August 24, 2024, but it was completed on October 10,2024, which was 47 days past the ARD. He stated that he does not know why it was not turned in on time. K. During a review of Resident 63's Admission Record, the Admission Record indicated Resident 63 was admitted to the facility on [DATE], with diagnoses which included atherosclerotic heart disease (a buildup of fats, cholesterol and other substances in and on the artery walls), schizophrenia (a mental illness that is characterized by disturbances in thought), and Hodgkin lymphoma (a type of cancer that develops in the lymph system). During a concurrent interview and record review on October 17, 2024, at 11: 53 AM, with RMN, Resident 63's clinical record titled, Centers for Medicare and Medicaid Services (CMS) Submission Report, was reviewed. Resident 63's MDS quarterly assessment record and ARD was on August 31, 2024, but it was completed on October 12,2024, which was 42 days past the ARD. He stated that he does not know why it was not turned in on time. L. During a review of Resident 66's Admission Record, the Admission Record indicated Resident 66 was admitted to the facility on [DATE], with diagnoses which included dementia (a progressive state of decline in mental abilities), diabetes (condition that happens when your blood sugar is too high), hypertensive heart disease (disease (problems with your heart that can develop if you have high blood pressure), and hyperlipidemia (an abnormally high concentration of fats or lipids in the blood). During a concurrent interview and record review on October 17, 2024, at 11:53 AM, with RMN, Resident 66's clinical record titled, Centers for Medicare and Medicaid Services (CMS) Submission Report, was reviewed. Resident 66's MDS quarterly assessment record and ARD was on August 26, 2024, but it was completed on October 12,2024, which was 47 days past the ARD. He stated that he does not know why it was not turned in on time. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	M. During a review of Resident 76's Admission Record, the Admission Record indicated Resident 76 was admitted to the facility on [DATE], with diagnoses which included fracture (a break in a bone) of right lower leg, and diabetes (high blood sugar). During a concurrent interview and record review on October 17,2024, at 11: 53 AM, with RMN, of Resident 76's clinical record titled, Centers for Medicare and Medicaid Services (CMS) Submission Report, was reviewed. Resident 76's MDS quarterly assessment record and ARD was on September 6, 2024, but it was completed on October 10,2024, which was 34 days past the ARD. He stated that he does not know why it was not turned in on time. During an interview with the Director of Nursing (DON) on October 17, 2024, at 3:51 PM, the DON stated the facility did not have a policy and procedure (P&P) regarding completion of the MDS assessments and the facility follows the guidelines from the RAI (Resident Assessment Instrument - helps gather definitive information on a resident's strengths and needs) manual. DON acknowledged that quarterly assessments were not submitted on time. She further stated that they don't have MDS nurse because previous MDS nurse left early of September of this year and current MDS nurse is on leave. During a review of CMS Long Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated October 2023, version 1.18.11, the manual indicated on pages 2-35, indicated, The Quarterly assessment is an OBRA (Omnibus Budget Reconciliation Act of 1987) non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. As such, not all MDS items appear on the Quarterly assessment. The ARD (A2300) must be not more than 92 days after the ARD of the most recent OBRA assessment of any type.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40171 Based on observation, interview, and record review, the facility failed to ensure two residents (Residents 14 and 11) received care and services as specified In their care plans (individualized plans for the medical care of a resident) when: 1) For Resident 14, the facility did not ensure staff kept the resident's smoking materials. This failure had the potential to result in in accident or injury to Resident 14 and other residents residing in the facility as a result of increased fire hazard. 2) For Resident 11, the facility did not ensure staff checked the residents blood sugar before meals. This failure has the potential to affect Resident 11's blood sugar management and could lead to inaccurate blood sugar readings, which may result improper insulin administration (medication use in the treatment and management of diabetes) and increased risk of hyperglycemia (elevated blood sugar). Findings: 1) During a review of Resident 14's clinical record, the Admission Record (contains medical and demographic information), indicated Resident 14 was admitted [DATE], with diagnoses which included Hemiplegia and hemiparesis (paralysis and weakness on one side of the body) on right dominant side, history of falls, and heart failure. During an interview on October 15, 2024, at 11:08 AM, with Resident 14, Resident 14 stated he was a smoker and kept his own smoking materials with him. During a concurrent observation, and interview, on October 17, 2024, at 4:09 PM, in Resident 14's room, with Resident 14, and in the presence of Certified Nursing Assistant 5 (CNA 5), Resident 14 was observed to have a nasal cannula (an oxygen delivery device) and was receiving oxygen. Resident 14 stated he kept his own smoking supplies in his bedside end table. CNA 5 opened Resident 14's bedside end table and there was one empty pack of cigarettes, another pack of cigarettes with 7 cigarettes left, and two lighters. During an interview on October 17, 2024, at 4:31 PM, with the Activities Director (AD), the AD stated staff were supposed to have Resident 14's smoking supplies and Resident 14 was not supposed to have any smoking supplies. During an interview on October 17, 2024, at 4:41 PM, with the Director of Nursing (DON), the DON stated Resident 14 was not supposed to keep his own smoking supplies and that the facility's practice was for staff to keep all smoking supplies. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 14's care plan titled, Resident is a smoker ., dated October 11, 2024, the care plan indicated, Interventions .Provide direct supervision to resident while smoking .smoking materials are to be kept by staff .Remove oxygen prior to smoking . During a review of Resident 14's Minimum data set (MDS - an assessment of a residents functional and health status), dated August 25, 2024, indicated Resident 14 had a Brief Interview for Mental Status score (BIMS score - a score of 0-15 used to determine cognitive functioning) of 12 (moderate cognitive impairment). During a review of Resident 14's Smoking Assessment-V1 (an assessment of the residents' level of risk associated with smoking), dated October 10, 2024, the assessment in section B. Cognitive indicated the resident was not able to recognize the smoking areas, and did not exhibit knowledge of the facility smoking rules. The Assessment section D. Current Tobacco Consumption per day, indicated the resident smoked 3-5 times a day. Section F. Safety, of the assessment indicated the resident was not able to hold, light and extinguish his own cigarettes, his personal items were not free from evidence of burn holes, the resident could not state or indicate that no smoking materials may be given to another resident and that the facility was to store the residents lighter and cigarettes. During a review of the facility's policy and procedure (P&P) titled, Smoking Policy - Residents, (undated), the policy indicated, This facility has established and maintains safe resident smoking practices .11. Residents without independent smoking privileges may not have or keep any smoking items, including cigarettes, tobacco, etc. except under direct supervision . 47098 2) During a review of Resident 11's Admission Record (contains demographic and medical information), indicated Resident 11 was admitted to the facility on [DATE] with the medical diagnoses which included diabetes (a condition where the body can't control the blood sugar level in the body). During an observation on October 17, 2024, at 7:34 AM, Resident 11 was seating in the dining room eating her breakfast. During an observation on October 17, 2024 At 7:51 AM in the dining room, staff were observed moving Resident 11 from the dinning room to her room to administer her medications. The Director of Nursing (DON) who was assisting the night shift License Vocational Nurse 3 (LVN 3) prepared to give Resident 11 her medications. During a futher observation on October 17, 2024 At 7:51 AM, the DON checked Resident 11's blood sugar, but Resident 11 had already started eating her meal. During a review of Resident 11's Physician Orders dated February 13, 2023, indicated, Novolog Insulin Aspart (a type of insulin to used to treat high blood sugar) inject as per sliding scale: if 70-119=4 [units of insulin] hold if blood sugar is below 70; 120-300=7 units of insulin], subcutaneously (below the skin) before meals for diabetes. Resident 11's blood sugar was to be checked before meals. During an interview with the DON on October 17, 2024, at 7:55 AM, the DON acknowledged that Resident 11's blood sugar should have been checked before the breakfast meal and not after. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 11's care plan (an individualized plan for the medical care of a resident), titled At risk for hyperglycemia and hypoglycemia related to diagnosis of Type 2 Diabetes Mellitus, undated, the care plan indicated Resident 11 was at risk for hyperglycemia (elevated blood sugar) and hypoglycemia (low blood sugar), with the goal of having no complications related to diabetes, evidenced by the absence of signs or symptoms of hyperglycemia or hypoglycemia. The interventions included: Administering insulin subcutaneously for Diabetes Mellitus Type 2 as ordered by the physician . During a concurrent interview, and record review, on October 18 at 9:01 AM with the DON, the facility 's policy and procedure (P&P) titled, Insulin Administration, undated, was reviewed. The P&P indicated, 1. Check blood glucose per physician order or facility protocol. The DON stated the P&P was not followed and acknowledged that Resident 11's blood sugar should have been checked before meals.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50575 Based on observation, interview, and record review, the facility failed to monitor and document the low air loss mattress (specialized mattress designed to help prevent and treat pressure ulcers) according to the physician's order for one of two sampled residents (Resident 40) who had a pressure ulcer (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence). This failure had the potential for Resident 40 not to receive the necessary treatment and services. Findings: A review of Resident 40's Admission Record, (contains demographic and medical information), indicated Resident 40 was admitted to the facility on [DATE], with diagnoses which included Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), and epilepsy (a disorder of the brain characterized by repeated seizures). During an observation on October 15, 2024, at 8:36 AM, Resident 40 was observed in her room, laying on her left side and asleep on a low air loss mattress bed. During a review of Resident 40's physician order, dated September 24, 2024, it indicated, Low Air Loss Mattress for tissue load management, check placement, setting, and monitor every shift. During a concurrent interview and record review on October 16, 2024, at 1:13 PM with the Treatment Nurse, Treatment Nurse stated Resident 40 has a stage 4 pressure ulcer (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) opening on her coccyx. The physician's order and Treatment Administration Record (TAR-a document that tracks the time and type of treatments administered to a patient) for Resident 40 were reviewed. Treatment Nurse acknowledged there is a gap or missing documentation on the following dates and shift indicating monitoring of low air loss mattress bed was not completed: a. October 1, 2024, day, and eve shift b. October 2, 2024, night shift c. October 3, 2024, night shift d. October 4, 2024, eve shift e. October 6, 2024, eve shift f. October 7, 2024, eve shift g. October 9, 2024, eve shift h. October 11, 2024, eve shift (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	i. October 12, 2024, eve shift j. October 13, 2024, eve, and night shift k. October 14, 2024, eve shift l. October 15, 2024, eve shift During a continued interview and observation with the Treatment Nurse, on October 16, 2024, at 1:14 PM, in Resident 40's room, Treatment Nurse demonstrated how she checks the low air mattress bed setting when she comes in every morning. She stated the low air mattress bed machine should be plugged in and set according to the red sticker. During an interview with the Licensed Vocational Nurse 1 (LVN 1) on October 17, 2024, at 9:19 AM, LVN 1 stated it is important to make sure Resident 40 is being repositioned. LVN 1 stated her, and the Treatment Nurse are responsible for monitoring low air loss mattress on day shift. She further stated it is important to check the settings of low air loss mattress because Resident's 40 main issue is her pressure ulcer. During a concurrent interview and record review on October 17, 2024, at 3:28 PM with Director of Nursing (DON), the Treatment administration record, for resident 40 was reviewed. The DON stated the nurse could have checked the low air mattress, and it could be just a documentation error. During a review of the care plan (an individualized plan for the medical care of a resident) for Resident 40, on October 17, 2024, at 6:29 PM, titled, At risk for skin breakdown related to history of pressure injury, immobility, Alzheimers, Dementia, Chronic Respiratory Failure, Bipolar disorder, dated September 24, 2024, the care plan interventions indicated Administer treatments as ordered and monitor for effectiveness. During a record review of the facility's policy and procedure titled, Pressure and Non-Pressure - Clinical Protocol, (undated), the policy indicated, Assessment and Recognition . 2. In addition, the nurse shall describe and document/report the following .d. Current treatments, including support surfaces

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40171 An immediate jeopardy (IJ- a situation that has threatened or is likely to threaten the health and safety of a resident) was called under F689 S483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents on October 16, 2024, at 4:53 PM, regarding the elopement of Resident 27 from the facility on October 16, 2024. An IJ was called in the presence of the Administrator. A corrective action plan was requested on October 16, 2024, at 4:53 PM. The immediate Jeopardy was removed after the corrective action plan was verified to be implemented through observations interviews, and record reviews on October 17, 2024, at 2:46 PM in the presence of the Administrator. Free of Accident Hazards / Supervision/Devices CFR (s): 483.25(d)(2)(2) S483.25 (d) Accidents. The facility must ensure that. S483.25(d)(1) The resident environment remains as free of accidents hazards as is possible; and S483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide supervision to one of 36 residents (Resident 27) in the locked memory care unit (a locked unit which is a secure area within the skilled nursing facility where people with dementia live. The locked unit prevents the residents from wandering off or leaving the facility willingly) on October 16, 2024, when staff was unaware Resident 27 (a confused resident with cognitive deficit and a history of falls) had left the facility. It was not until Surveyor 1 (a member of a survey team not employed by the facility) informed facility staff that the resident had eloped (the act of leaving the premises or safe area without authorization or supervision to do so) and was in a field adjacent to the facility building. This failure had the potential to result in serious harm or death to Resident 27 who was at risk for injuries which may occur as a result of being exposed to environmental elements, accident hazards or being without resources such as food, water and shelter. Findings: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 27's clinical record, the Admission Record (contains medical and demographic information), it indicated Resident 27 was initially admitted to the facility on [DATE], with diagnoses which included dementia (a chronic condition that causes a decline in mental functioning, such as thinking, remembering, and reasoning, that interferes with daily life), encephalopathy (any brain disease, disorder, or damage that affects the brain's structure or function), altered mental status, fall on or from other stairs and steps [subsequent encounter], unsteadiness on feet, and hemiplegia (paralysis on one side of the body). During a review of Resident 27's Minimum data set (MDS - an assessment of a residents functional and health status), dated August 19, 2024, section GG0115 indicated Resident 27 had lower extremity impairment on both sides (impairment in both legs) in section, Functional Limitation in Range of Motion -code for limitation that interfered with daily functions or placed resident at risk of injury in the last 7 days . Further review of Resident 27's MDS dated [DATE], indicated the type of assistance the resident required for walking 10 feet included, supervision or touching assistance - helper provides verbal cues and/or touching/steadying and/or contact guard assistance [caregiver places one or two hands on the patient's body to help with balance but provides no other assistance to perform the functional mobility task] as resident completes activity . During a review of Resident 27's Interdisciplinary Team Note (IDT - A group of professionals from different disciplines that work together to meet the needs of residents using their different perspectives and expertise.), dated October 16, 2024, the IDT note indicated Resident 27 had .confusion and disorientation secondary to diagnosis of dementia. His BIMS score [Brief Interview for Mental Status score - a score of 0-15 used to determine cognitive functioning] is 6 [severe impairment] and does not have the capacity to make decisions . During a review of Resident 27's Physical Therapy PT Evaluation & Plan of Treatment, with a certification period of July 30, 2024, through August 28, 2024, the physical therapy evaluation indicated, .Reason for referral/current illness: Patient referred to PT [physical therapy] due to new onset of decrease in functional mobility, falls/fall risk and increased need for assistance from others .PMHX [past medical history] Pt [patient] .change in function post fall with facial bruising .hx [history] of fall at home with difficulty walking and encephalopathy . and decreased cognition . Further review of the Physical Therapy PT Evaluation & Plan of Treatment, indicated the resident had impaired functioning in his left and right hip, knee, and ankle and his Safety Awareness was impaired. During a review of Resident 27's care plan (an individualized plan for the medical care of a resident), titled, [name of Resident 27] has hesitancy to ambulate [walk] and unsteady shuffling gait which limits physical mobility, dated September 9, 2024, the care plan indicated, .Goal .will remain free of complications related to immobility, including .fall related injury through the next review date .will maintain current level of mobility 2 person assist for 15 ft [feet] through review date .Interventions - Provide supportive care, assistance with mobility as needed . During an observation on October 16, 2024, at 11:08 AM, Resident 27 was observed by Surveyor 1 to be walking unassisted in a field behind the facility's parking lot. There was no staff nearby or within eyesight of the resident. During an interview on October 16, 2024, at 11:11 AM, the Administrator (ADMIN) was informed by Surveyor 1 that Resident 27 was in a field next to the parking lot and was unaccompanied by staff. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on October 16, 2024, at 12:15 PM, with the ADMIN, the ADMIN stated supervision in the locked memory care unit included a supervising Licensed Vocational Nurse (LVN), and Certified Nursing Assistants (CNAs) with a one to 10 ratio (1 CNA per 10 residents). The ADMIN further stated on October 16, 2024, it was a surveyor (Surveyor 1) who initially informed him that Resident 27 had left the facility and was in a field. The ADMIN stated facility staff were unaware Resident 27 had left the facility prior to notification from the surveyor. The ADMIN stated he believed Resident 27 had exited out the facility door (which led to the outside) at the far end of a hallway, within the locked memory care unit, and then jumped over a locked gate. Upon being brought back into the facility by staff, the ADMIN stated Resident 27 told him he had jumped over the locked gate. The ADMIN further stated the facility exterior door remained unlocked, but the gate was locked with a keypad code that staff would enter and exit the facility through to gain access to the laundry room and garbage dumpster. When asked if the facility exterior door had an audible alarm to indicate the door had been opened, the ADMIN stated the door had not been alarmed since he started working at the facility within the last three years. During an interview on October 16, 2024, at 12:26 PM, with Certified Nursing Assistant 1 (CNA 1) stated on October 16, 2024, he was at lunch when he received a phone call at 11:13 AM from CNA 2 informing him Resident 27 had left the facility building and was in a field. CNA 1 further stated there was supposed to be at least one CNA stationed in each of the two halls in the memory care unit to provide supervision to the residents. CNA 1 stated he informed CNA 2 and a charge nurse that he was going to lunch, and it was CNA 2 who was supposed to be supervising residents while he was at lunch at the time Resident 27 eloped. CNA 1 stated the door leading to the exterior of the building (in the hall in which Resident 27 allegedly eloped from), used to have an alarm in the past but did not any longer. During an interview on October 16, 2024, at 12:43 PM, with CNA 2, CNA 2 stated the memory care unit (two total hallways) was supposed to have at least one CNA supervising each hallway. CNA 2 further stated there was usually four CNAs assigned to the memory care unit (2 for each hallway), but at the time Resident 27 had eloped, the two CNAs (CNA 1 and CNA 4) assigned to the hallway where Resident 27's room was located and where the door Resident 27 used to go outside was also located, were at lunch at the same time. CNA 2 stated she was assigned to the other hallway but was tasked with supervising both hallways. When asked where CNA 3 was (the third of four CNAs assigned to the memory care unit), CNA 1 stated CNA 3 was in the activity room (located in the memory care unit) and that CNA 3 was supposed to be helping her supervise the residents but did not know why CNA 3 was in the activity room instead. CNA 2 stated she also saw Licensed Vocational Nurse 1 (LVN 1) at the nurses' station in the memory care unit. During an interview on October 16, 2024, at 1:07 PM, with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated there were four CNAs assigned to the memory care unit to supervise residents. LVN 1 further stated the CNA's in the halls were supposed to take lunch opposite each other so there was one CNA at a time taking a lunch from each hallway. This would leave one CNA in each hallway to supervise residents. LVN 1 stated she was just covering the lower dementia [locked memory care unit] unit as extra eyes while LVN 2 was at lunch. LVN 1 further stated she was aware CNA 1 was on lunch but didn't know if any of the other CNAs were on lunch or break. LVN 1 stated she saw CNA 2 supervising the hallways but didn't see any other CNAs in the hallways. LVN 1 stated she was aware CNA 3 was providing supervision to residents in the activity room. LVN 1 stated LVN 2 came back from her lunch at approximately 11:05 AM and she (LVN 1) then went to lunch while LVN 2 went to go check a resident's blood sugar (test to determine the level of sugar in the blood) in a resident's room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on October 16, 2024, at 1:30 PM, with LVN 2, LVN 2 stated she came back from lunch and at the time Resident 27 eloped, she was doing a blood sugar check on a resident in the resident's room. LVN 2 further stated she knew CNA 1 was supervising the halls but did not know where CNA 4 was. During an interview on October 16, 2024, at 1:39 PM, with CNA 3, CNA 3 stated she was supervising the hallways earlier in the day but was asked by an activities staff member to come and help provide supervision in the activities room because there was more than 10 residents in the activity room and they needed more than 1 staff member to provide supervision. CNA 3 further stated she was aware CNA 1 and CNA 4 were on lunch which meant there was only her and CNA 2 left to supervise the hallways but stated she (CNA 3) could only be in one place at a time so she decided to go to the activity room to help the activities staff member. CNA 3 stated after approximately 20-30 minutes of being in the activity room, she was walking back to the hallway from the activity room when she was made aware Resident 27 had eloped. During a concurrent observation and interview on October 16, 2024, at 5:24 PM, with Resident 27, Resident 27 was observed to be in his room which was located immediately adjacent to a facility exit door located at the end of the hallway where there was a locked gate upon exiting the building. Resident 27 was alert and oriented x (times) 1 (one) (oriented to person but not oriented to place, time, or situation). Resident 27 stated he didn't know where he was, what day or month it was and stated he thought he was on TV during our discussion. Resident 27 was unable to answer if he recalled if or how he left the facility. During an interview on October 18, 2024, at 9:59 AM, with the Director of Staff Development (DSD), the DSD stated the staffing schedule (in use at the time Resident 27 eloped) did not indicate who was supposed to cover each hallway during staff breaks and lunches and it was facility practice to ensure verbally with each other that there was someone in each hallway to supervise residents. During a review of the facility's policy and procedure (P&P) titled, Elopement/Unsafe Wandering, dated December 2023, the P&P indicated, This facility is committed to promoting resident autonomy by providing an environment that remains as free of accident hazards as possible. Each resident is assisted in attaining or maintaining their highest practicable level of function through providing the resident adequate supervision and diversional programs to prevent unsafe wandering while maintaining the least restrictive environment for those at risk for elopement .Elopement is when a resident leaves the facility premises or a safe area without authorization (i.e. [for example] an order for discharge or leave of absence) and/or any necessary supervision to do so . An Immediate Jeopardy (IJ-a situation that has threatened or is likely to threaten the health and safety of a resident) was called under F689 S483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents on October 16, 2024 at 4:53 PM, after it was determined that Resident 27 did not receive supervision and monitoring required to keep the resident safe on October 16, 2024, when the resident was found to have eloped from the facility and was found by a surveyor in a field behind the facility's parking lot. The IJ was called in the presence of the Administrator (ADMIN). A Corrective Action Plan (CAP-a plan which includes interventions to remove the potential or actual harm of an immediate jeopardy situation) was requested and a preliminary CAP was received on October 17, 2024, at 12:48 PM and included the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- On October 16, 2024, upon notification of incident, Resident 27 was assessed by the Director of Nursing (DON) and a physician. Body assessment was done with no apparent injury. The attending physician ordered Complete Blood Count (CBC - blood tests), Complete Metabolic Panel (CMP-blood tests) and Urinalysis with culture and sensitivity (urine tests) STAT (immediately). - Resident 27 was placed on 72-hour change of condition (change in a resident's health or functioning that can be short-term or significant) monitoring and 1:1 (one on one) supervision with closed visual check. No change was noted related to incident. - On October 16, 2024, the Facility Administrator installed a functional audio alarm system on all exit doors in the lower unit. - All exterior doors in the lower/Memory care unit will be checked every 15 minutes by a designated staff for the next 30 days along with the installation of alarm system. - Director of Nursing and designees evaluated 80 residents' elopement and wandering risk on October 16, 2024, to identify any residents that were at high risk for elopement and wandering. No other residents were affected. - Director of Nursing and designees ensured that identification of all 80 residents was in place such as wrist bands and or photo on the electronic medical record (PCC) on October 16, 2024. All residents had a wrist band and/or photos were uploaded in PCC. - Facility staff received an in-service and training from the Director of Staff Development (DSD) on October 16, 2024, regarding Policy and Procedure Incident/Accident with emphasis with Elopement/Wandering Incidents. In-services will continue October 17, 2024, and will be given to all staff before the beginning of their next shift. - Director of Staff Development initiated in-service with the Licensed Nurses and Certified Nursing Assistants on October 16, 2024, about coverage during breaks and lunch. The licensed nurse is responsible for creating the daily shift assignment form including the scheduled break and lunch time to ensure that the floor has adequate staff and supervision provided to the residents. In an event that a staff is running late for the scheduled break and lunch, it is the staff's responsibility to notify the Charge Nurse or Registered Nurse (RN) supervisor so that, if necessary, the Licensed Nurse can make the adjustment to ensure adequate supervision is provided to the residents. In-services will continue October 17, 2024 and be given to all licensed nurses and certified nursing assistants before the beginning of their next shift. - Director of Staff Development and or Charge Nurse will ensure that daily shift assignment is completed and scheduled breaks and lunch time is covered. - Administrator initiated the in-service on October 16, 2024, regarding the policy, monitoring, and maintenance alarm system in all exterior door in the lower unit. - All Exterior doors in the lower unit will be checked every 15 minutes. - Maintenance Supervisor will test the alarms weekly and will be maintained according to manufacturer guideline. (continued on next page)

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	056365	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yucaipa Hills Post Acute	13542 Second St. Yucaipa, CA 92399

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- A log of maintenance and testing will be kept by the Maintenance Supervisor The acceptable corrective action was verified with the facility to be implemented through observation, interview, and record review. The IJ was removed on October 17, 2024, at 2:46 PM, in the presence of the Administrator.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47098 Based on observation, interview, and record review, the facility failed to document a gradual dose reduction (GDR) for one of eight sampled residents (Resident 55) when a recommended a decrease in Trazadone (a medicine that helps people who are feeling very sad or having trouble to sleep) from 100 mg (milligrams unit of measurement) to 50 mg was not done and documented. This failure has the potential to result in over medication and increased risk of side effects for Resident 55. Finding: During a review of Resident 55's Admission Record (contains demographic and medical information), indicated Resident 55 was admitted to the facility on [DATE], with diagnoses which included major depressive disorder (a mental health condition characterized by persistent sadness and loss of interest), and bipolar disorder (a mental health condition where a person has extreme mood swings). During a review of Resident 55's pharmacist's recommendation dated October 7, 2024, indicated a recommended GDR of Trazadone dose from 100 mg to 50 mg due to the Resident 55's stable condition. During a review of Resident 55's physician orders for October 2024, there is no documented evidence Trazadone has been decreased from 100 mg to 50 mg. Further review of Resident 55's physician's orders indicated Resident 55 has been receiving trazadone 100 mg since June 5, 2024. During a review of Resident 55's care plan (an individualized plan for the medical care of the resident) titled, Depression Management, undated, the care plan indicated Resident 55 had episodes of depression manifested by inability to sleep. The goal was to minimize the risk of adverse side effects of medication usage, including Trazadone, through appropriate interventions. The interventions included administer antidepressant medication as per physician's order, monitor and record episodes of behavior per psychotropic policy .Gradual Dose Reduction (GDR) as indicated . During a review of the Resident 55's Nurse Practitioner's (NP) Progress notes dated October 7, 2024, the NP progress notes indicated Resident 55 had been evaluated and was found to be stable. A GDR for Trazodone was recommended reducing the dose from 100 mg to 50 mg. Further review of NP's progress notes dated October 7, 2024; it indicated Resident 55 had agreed to the GDR during the NP's evaluation. During an observation, and interview, with Resident 55's on October 17, 2024, at 2:29 PM, Resident 55 was observed lying down on her bed with her eyes open and able to verbalize her needs. Resident 55 agree to be interviewed and she was aware she had been taking Trazadone 100 mg at night because it helps her sleep. Resident 55 expressed that she wanted to continue taking this dose. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on October 15, 2024, at 5:16 PM with Director of Nurses (DON), the DON confirmed that Resident 55 was still taking Trazodone 100 mg per the physician's orders. The DON further explained that she had attempted to obtain Resident 55's consent for the dose reduction, but Resident 55 refused, expressing her preference to continue with the Trazadone 100 mg dose. The DON further stated that she notified the Nurse Practitioner (NP) of Resident 55's decision to continue with Trazadone 100 mg but acknowledged that she forgotten to document both Resident 55's refusal of GDR and the communication with the NP. The DON agreed this was a discrepancy in her documentation and that it should have been recorded. During an interview on October 18, 2024, at 9:07 AM, with the DON, the facility's policy, and procedure (P&P) titled, Nursing Documentation dated December 2023, was reviewed. The P&P indicated, 3. Refusal of treatments: Documentation pertaining to resident refusal of treatment should include: A. the date and time the treatment was attempted. B. The treatment attempted .D. Documentation that the resident was informed of the purpose of the treatment and the consequences of not receiving the care . The DON acknowledged the P&P was not followed and agreed Resident 55's refusal of the GDR and the communication with NP should have been documented.

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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. 47098 Based on observation, interview, and record review, the facility failed to follow its policy and procedure (P&P) for labeling and dating of food items when a bottle of [brand name] creamer was found on top of a table inside the kitchen at room temperature without an open date. This failure has the potential to increase the risk of foodborne illness or contamination due to improper storage practices. Finding: During an observation on October 14, 2024, at 8:16 AM, during a tour inside the kitchen area, a bottle of [brand name] coffee creamer was observed on top of a table inside the kitchen area. The bottle was open and halfway already used, and there was no open date written on the bottle to indicate when it was first opened. During an interview on October 14, 2024, at 8:18 AM, with the Dietary Services Supervisor, (DSS 1), the DSS 1 confirmed that the creamer was found open, used and unlabeled. The DSS 1 stated that the bottle of creamer should be labeled and properly stored according to facility's P&P. The DSS 1 further stated that the bottle of creamer will be dispose immediately. During a concurrent interview, and record review, on October 18, 2024, at 8:50 AM, with the DSS 1, the facility's P&P titled, Labeling and dating of foods dated 2023, was reviewed. The P&P indicated, All food items in the store room, refrigerator, and freezer need to be labeled and dated .Procedure: Newly opened food items will need to be closed and labeled with an open date and used by the date that follows the various storage guidelines .

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40171 Based on observation, interview, and record review, the facility failed to ensure two of 46 resident's rooms (rooms [ROOM NUMBERS]) had the required 80 square feet (Sq Ft - unit of measurement) of space for each resident. This failure had the potential to limit freedom of movement and affect the health and safety of four residents (Resident 55, 28, 64, and 44) who reside in the two rooms. Findings: During an interview with the Administrator (ADMIN) on October 17, 2024 at 8:11 AM, the ADMIN stated the facility has two rooms with square footage waivers, rooms [ROOM NUMBERS]. The ADMIN further stated the facility submitted a room waiver variance sometime within the last week. During concurrent observations, and interviews with the residents (55 and 28) in room [ROOM NUMBER], on October 17, 2024 at 8:13 AM the following were observed: Bed 7A was occupied by Resident 55, who was observed resting comfortably in bed. Resident 55 did not verbalize any issues or concerns with the size of the room. There were no concerns with the beds, bedside tables, and wheelchairs which are accessible to the room. Bed 7B was occupied by Resident 28, who was observed resting comfortably in bed. Resident 28 did not verbalize any issues or concerns with the size of the room. There were no concerns with the beds, bedside tables, and wheelchairs which are accessible to the room. During concurrent observations, and interviews with the residents (Resident 64 and 44) in room [ROOM NUMBER], on October 17, 2024, at 8:19 AM, the following were observed: Bed 11A was occupied by Resident 64, who was observed in the room. Resident 64 did not verbalize any issues or concerns with the size room. There were no concerns with the beds, bedside tables, and wheelchairs which are accessible to the room. Bed 11B was occupied by Resident 44, who was observed in the room. Resident 44 did not verbalize any issues or concerns with the room. There were no concerns with the beds, bedside tables, and wheelchairs which are accessible to the room. During an environmental tour of rooms [ROOM NUMBERS], with the Maintenance Director on October 17, 2024 at 8:13 AM, the following measurements were noted as follows: 1. room [ROOM NUMBER] measured 12 feet 10 inches x 11 feet 4 inches = 145.43 square feet total (72.7 square feet per resident)room [ROOM NUMBER] did not have the required 80 square feet (Sq Ft - unit of measurement) of space for each resident. (continued on next page)

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. room [ROOM NUMBER] measured 12 feet 9 inches x 11 feet 2 inches = 142.61 square feet total (71.3 square feet per resident)room [ROOM NUMBER] did not have the required 80 square feet (Sq Ft - unit of measurement) of space for each resident. During the course of the survey, rooms [ROOM NUMBERS] were not crowded and did not impose any safety hazards. There were no complaints of space or room issues from the residents occupying these rooms.