STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056485	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arlington Gardens Care Center	3688 Nye Avenue Riverside, CA 92505

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 35314 Based on observation, interview, facility document review, and facility policy review, the facility failed to ensure the survey results were accessible to residents and family members. This had the potential to affect all 98 residents that resided in the facility. Findings included: A facility policy titled, Examination of Survey Results, dated 03/2017, revealed, Survey reports and plan of corrections are readily available to the resident, family members, representatives and to the public. The policy revealed, 2. A copy of the most recent survey report and any plans of correction are kept in a binder in the resident's day room. An Admission Record indicated the facility admitted Resident #29 on 03/18/2019. According to the Admission Record, Resident #29 was their own responsible party. During an interview on 07/10/2024 at 10:31 AM, Resident #29 revealed the survey binder had been available at the front entrance previously. Resident #29 stated the facility had moved the binder and had not provided the previous survey results for them to review. Resident #29 stated they had reviewed the binder two years ago and found the findings interesting and had not seen the binder again. An observation of an enclosed bulletin board on 07/11/2024 at 2:13 PM revealed signage that stated, Survey Binder is located by the front entrance near the receptionist desk. An observation and concurrent interview on 07/11/2024 at 2:15 PM of the receptionist desk revealed no evidence of the survey results. The Receptionist stated she had worked at the facility as the receptionist for one year. She revealed the survey results binder was not located at the desk. She stated she had never seen a survey binder at the desk. She searched all locations in her area and revealed no survey results. An interview with Human Resources (HR) Payroll on 07/11/2024 at 2:23 PM revealed he had an office across from the receptionist desk. He revealed he was not aware of the location of the survey results. He revealed he asked the Administrator about the survey results binder and the Administrator did not know the location of the survey results. He completed a search of the receptionist area and could not locate the survey results. (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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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 07/11/2024 at 2:26 PM, the Director of Nursing (DON) revealed she was unable to locate the survey results binder. During a follow-up interview on 07/11/2024 at 2:42 PM, HR Payroll revealed the facility was able to locate the survey results binder. He revealed the survey results binder had been in the DON's office. He stated it was not located where the posting had suggested. During an interview on 07/11/2024 at 4:40 PM, the Administrator revealed the survey binder was removed from the receptionist area after an incident. He stated that he expected the survey results to be accessible to residents and family members. During a follow-up interview on 07/12/2024 at 11:25 AM, the DON revealed the survey results binder should be at the receptionist desk as the posting reflected. She stated she was not aware the results were not available and located in her office.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 40141 Based on interview, record review, facility policy review, and review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, the facility failed to ensure a quarterly Minimum Data Set (MDS) assessment was completed timely for 1 (Resident #37) of 19 resident MDS assessments reviewed. Findings included: A facility policy titled, Resident Assessments, revised 10/2023, specified, 4. Non-Comprehensive MDS assessments include a select number of items from the MDS used to track the resident's status between comprehensive assessments and to ensure monitoring of critical indicators of the gradual onset of significant changes in resident status. The policy revealed, Non-comprehensive assessments include Quarterly assessments and SCQAs [significant correction to prior quarterly assessment]. The policy revealed, 5. The RAI [Resident Assessment Instrument] User's Manual (Chapter 2) provides detailed information on timing and submission of assessments. The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2023, revealed under 05. Quarterly Assessment The MDS completion date (item Z0500B) must be no later than 14 days after the ARD [Assessment Reference Date] (ARD + 14 calendar days). An Admission Record revealed the facility admitted Resident #37 on 10/31/2022. According to the Admission Record, the resident had a medical history that included a diagnosis of encephalopathy (degenerative brain disease). A quarterly MDS, with an ARD of 06/14/2024, revealed the section for the Signature of RN [registered nurse] Assessment Coordinator Verifying Assessment Completion was blank, indicating the assessment had not been completed. During an interview on 07/11/2024 at 3:56 PM, the Administrator stated information for the MDS assessment was pulled from many different sources like charting and what was happening in the facility. The Administrator stated he expected for MDS assessments to be completed timely. During an interview on 07/12/2024 at 10:36 AM, MDS Nurse #3 stated that for timeliness the MDS was typically started based on the ARD. MDS Nurse #3 stated the facility had 14 days from the ARD to complete the assessment then the RN signed the MDS. MDS Nurse #3 stated when signed, the MDS was considered complete, and the 14 days started to get the MDS transmitted. MDS Nurse #3 stated the RNs were supposed to check the MDS list and sign them daily. MDS Nurse #3 stated Resident #37's quarterly MDS should have been completed 14 days from the ARD. MDS Nurse #3 stated she had signed Resident #37's MDS on 06/27/2024, and the RN signed it on 07/10/2024. MDS Nurse #3 stated Resident #37's quarterly MDS was not completed timely. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/12/2024 at 11:08 AM, the Director of Nursing (DON) stated she was not sure of the exact timeline for MDS completion, but she expected the MDS Nurse to know and get everything submitted on time. The DON stated the MDS Nurse reminded the RNs to sign the MDS and once the MDS was signed then it was considered completed.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35314 Based on interview, record review, facility document review, and facility policy review, the facility failed to ensure the Minimum Data Set (MDS) was accurate for 1 (Residents #103) of 19 residents reviewed for accurate assessments. Findings included: A facility policy titled, Resident Assessment, revised 10/2023, revealed, 11. All persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information. 12. Information in the MDS assessments will consistently reflect information in the progress notes, plans of care and resident observations/interviews. An Admission Record revealed the facility originally admitted Resident #103 on 01/12/2024 and readmitted the resident on 03/29/2024. The Admission Record revealed Resident #103 was discharged from the facility on 04/09/2024. A discharge MDS, with an Assessment Reference Date (ARD) of 04/09/2024, revealed Resident #103 had discharged to a short-term general hospital. The MDS revealed the resident had discharged on [DATE]. Resident #103's Discharge Summary - [Facility Name] V2.1 dated 04/09/2024 revealed the reason for discharge was the resident progressed with therapy and was able to discharge back home safely per the medical doctor and the resident's request. The summary revealed the resident's discharged location was home. Resident #103's Progress Notes dated 04/09/2024, revealed the resident had discharged home with a family member. During an interview on 07/11/2024 at 3:56 PM, the Administrator revealed he expected the MDS to be accurate. During an interview on 07/12/2024 at 10:35 AM, MDS Nurse #3 stated when a resident discharged home the MDS should reflect the resident went home and not to the hospital. She stated it was a mistake to document Resident #103 had gone to the hospital. During an interview on 07/12/2024 at 11:02 AM, the Director of Nursing (DON) stated she expected the MDS to be accurate. The DON stated the MDS Nurse should have reviewed the progress notes.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities 40141 Based on interview, record review, facility document review, and facility policy review, the facility failed to ensure Preadmission Screening and Resident Review (PASRR; PASARR) Level I screenings were accurate for 3 (Residents #3, #18, and #59) of 3 residents reviewed for PASRR. Findings included: A facility policy titled, Admission Criteria PASARR, revised 03/2019, indicated, 9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. A. The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source. to [sic] determine if the individual meets the criteria for a MD, ID, or RD. b. If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process. (1) The admitting nurse notifies the social services department when a resident is identified as having a possible (or evident) MD, ID, or RD. The policy revealed, 11. The State may choose not to apply the preadmission screening requirement if: c. the Attending Physician has certified (prior to admission) that the individual will likely need less than 30 days of care at the facility. 1. An Admission Record revealed the facility admitted Resident #3 on 01/19/2024. According to the Admission Record, the resident had a medical history that included diagnoses of dementia, bipolar disorder, major depressive disorder, and schizophrenia. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/26/2024, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had severe cognitive impairment. The MDS revealed the resident had diagnoses of depression and bipolar disorder. Resident #3's Level I PASRR letter dated 01/19/2024 specified the Level I PASRR was exempt. The letter specified if the individual remained in the nursing facility longer than 30 days, the facility should resubmit a new Level I screening on the 31st day. During an interview on 07/11/2024 at 3:58 PM, the Administrator reviewed Resident #3's Level I PASRR screening and indicated it should have been resubmitted after the 30 days, on the 31st day. The Administrator stated he expected the Level I PASRR to be resubmitted timely. During an interview on 07/12/2024 at 11:14 AM, the Director of Nursing (DON) stated Resident #3's Level I PASRR screening should have been resubmitted. 35314 2. An Admission Record revealed the facility admitted Resident #18 on 01/01/2024. According to the Admission Record, the resident had a medical history that included diagnoses of unspecified psychosis not due to a substance and major depressive disorder. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/09/2024, revealed Resident #18 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had diagnoses of depression (other than bipolar) and psychotic disorder (other than schizophrenia). Resident #18's Preadmission Screening and Resident Review (PASRR) Level I Screening dated 01/01/2024, revealed the resident did not have a serious diagnosed mental disorder such as depression or symptoms of psychosis. The screening revealed the results of the Level I screening were negative. A letter from the Department of Health Care Services dated 01/01//2024 revealed Resident #18' Level I screening was negative, the resident did not have a mental illness, and a Level II evaluation was not required. During an interview on 07/09/2024 at 1:45 PM, MDS Nurse #3 stated she had not been involved in the PASARR process; they were completed by the hospital. She stated the Director of Nursing (DON) completed any revisions to the Level I screening and communicated with PASARR services if a new Level I was required. During an interview on 07/11/2024 at 3:56 PM, the Administrator stated the DON was responsible for completing in-house Level I PASARR screenings. The Administrator stated the DON was responsible for ensuring they were up to date and were accurate. During an interview on 07/12/2024 at 11:08 AM, the DON stated that the facility received the Level I PASARR from the hospital before the resident arrived. The DON stated the admission staff reviewed the PASARRs. The DON stated the facility ensured that each resident had a Level I completed. The DON stated if the PASARR were not accurate, she was responsible for completing another Level I screening. The DON stated Resident #18's Level I screen was missed; it should have included the resident's diagnoses. 46258 3. An Admission Record revealed the facility admitted Resident #59 on 12/07/2022. According to the Admission Record, the resident had a medical history that included diagnoses of anxiety disorder, and major depressive disorder. A quarterly MDS, with an Assessment Reference Date (ARD) of 06/04/2024, revealed Resident #59 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated Resident #59 had a diagnoses of anxiety disorder, depression, and schizophrenia. Resident #256's Care Plan included a focus area initiated 02/15/2024, that revealed Resident #59 was at risk for decreased psychosocial well-being, adjustment issues, emotional distress and ineffective coping skills, poor impulse control, adverse effects on function, mental, physical, social or spiritual well-being related to being in a skilled nursing facility and a diagnosis of depression. The Care Plan also included a focus, initiated 06/25/2024, that indicated Resident #59 required anti-anxiety medication related to an anxiety disorder as evidenced by verbalization of feelings of nervousness and anxiety. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #256's Preadmission Screening and Resident Review (PASRR) Level I Screening, dated 01/27/2024, revealed a negative Level I outcome due to a 30-day exempted hospital discharge. Resident #256's State of California - Health and Human Services Agency Department of Health Care Services letter, dated 01/27/2024, specified, If the individual remains in the NF [nursing facility] longer than 30 days, the facility should resubmit a new Level 1 Screening as a Resident Review on the 31st day. During an interview on 07/11/2024 at 3:56 PM, the Administrator stated the DON was responsible for completing in-house Level I PASARR screenings. The Administrator stated the DON was responsible for ensuring they were up to date and were accurate. During an interview on 07/12/2024 at 11:08 AM, the DON stated that the facility received the Level I PASARR from the hospital before the resident arrived. The DON stated the admission staff reviewed the PASARRs. The DON stated the facility ensured that each resident had a Level I completed. The DON stated if the PASARR were not accurate, she was responsible for completing another Level I screening.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 46258 Based on interview, record review, facility document review, and facility policy review, the facility failed to ensure a medication allergy was documented for 1 (Resident #256) of 5 residents reviewed for unnecessary medications. Findings included: A facility policy titled, Admission Assessment, revised 09/2012, specified, The purpose of this procedure is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan, and completing required assessment instruments, including the MDS [Minimum Data Set]. An Admission Record revealed the facility admitted Resident #256 on 06/30/2024. According to the Admission Record, the resident had a medical history that included diagnoses of fracture of the left femur, aftercare following joint replacement surgery, pain due to internal orthopedic prosthetic devices, implants and grafts, dementia, and major depressive disorder. Resident #256's Care Plan included a focus area initiated 07/01/2024, that indicated the resident was at risk for pain or discomfort due to arthritis, depression, fractures, recent falls, recent injury, recent surgery, and wounds. Resident #256's History and Physical Reports, dated 06/26/2024, revealed an allergy to hydrocodone; the severity of the allergy was unknown. The report revealed Resident #256's reactions to hydrocodone included the resident would become angry very easily and displayed uncooperative behavior. Resident #256's Order Summary Report with active orders as of 07/10/2024 revealed an order dated 07/03/2024 for Norco (hydrocodone/acetaminophen; a pain reliever) 5-325 milligrams (mg), with instructions to give one tablet by mouth every six hours as needed for moderate to severe pain. The Order Summary Report revealed the resident had no known allergies. Resident #256's Medication Administration Record [MAR] for the timeframe from 07/01/2024 through 07/08/2024 revealed Resident #256 received Norco 5-325 mg on 07/04/2024, 07/05/2024, 07/06/2024, 07/07/2024, and 07/08/2024. During an interview on 07/08/2024 at 2:05 PM, Resident #256's Family Member (FM) #6, stated Resident #256 had gotten mean and aggressive since their admission to the facility and had been saying words they have never heard the resident say. During an interview on 07/12/2024 at 9:50 AM, Registered Nurse (RN) #7 stated medication allergies were entered into the resident's chart by the unit supervisor on duty when the resident got admitted . During an interview on 07/12/2024 at 11:08 AM, the Director of Nursing (DON) stated the RN supervisor received the information from the hospital and was to enter it in the resident's chart. The DON stated Resident #256's allergy did get missed but was not sure how it was missed.

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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. 46258 Based on interview, record review, facility document review, and facility policy review, the facility failed to ensure a resident was safe from eloping from the facility for 1 (Resident #91) of 3 residents reviewed for elopements. The failure resulted in Resident #91 leaving the facility during an excessive heat wave, leading to a visit to the emergency room . Findings included: A facility policy titled, Elopements, revised on 12/2007, indicated, Staff shall investigate and report all cases of missing residents. The policy revealed, 1. Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing. An Admission Record revealed the facility admitted Resident #91 on 06/11/2024. According to the Admission Record, the resident had a medical history that included diagnoses of cerebral infarction (stoke), muscle weakness, and difficulty in walking. An admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/18/2024, revealed Resident #91 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #91 had not exhibited wandering behaviors during the assessment period. The MDS indicated the resident's family wanted the goal for Resident #91 to be discharged to the community. A review of Resident #91's Care Plan included a focus area initiated on 06/12/2024 that indicated Resident #91 was admitted for short-term care. The focus area revealed the resident would discharge home versus placement at another facility when able. The Care Plan included a focus area initiated 07/09/2024, that indicated Resident #91 was an elopement risk; the resident had a history of attempting to walk outside. An intervention, initiated 07/09/2024, indicated Resident #91 would have a one-on-one sitter. Further review revealed interventions that directed staff to document the resident's wandering behavior and attempted diversional interventions in the behavior log. Resident #91's Baseline Care plan Person-Centered Care Planning - V3.1 form dated 06/12/2024, indicated Resident #91 was not an elopement risk. Resident #91's 06. Nursing- Elopement Risk Observation/Assessment - V 3.1 form dated 06/11/2024, revealed Resident #91 had an Elopement Risk Score of 2, which indicated Resident #91 was not an elopement risk. Resident #91's hospital ED [emergency department] Provider Note dated 07/08/2024, revealed the resident's case was discussed with the facility. The note revealed Resident #91 escaped from the facility and was wandering in the street when they were found by a police officer. The Medical Decision Making section of the ED Provider Note, revealed, while in the ED, Resident #91 appeared to have stable vital signs and was not immediately compromised or in distress. Further review revealed Resident #91 was stable and able to return to the facility for rehab from their stroke and memory care. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #91's SBAR [situation, background, appearance, review and notify] Communication Form and Progress Notes for RNs [registered nurse]/LPN [licensed practical nurse]/LVN [licensed vocational nurse], dated 07/08/2024, revealed that according to the charge nurse's report, the residents spouse came looking for the resident around 11:50 AM. The SBAR notes revealed the charge nurse checked the resident's room and they were not there. According to the SBAR notes, Resident #91 was last seen at 8:50 AM the same morning at the gym and then approximately 10:30 AM in the television room near the nurse's station. The SBAR notes revealed the RN announced that a resident was missing from their room and facility staff were given the resident's identification and that staff were extensively searching the facility and surroundings. Resident #91's Progress Notes *NEW*, dated 07/09/2024, revealed at 12:16 PM the local Police Department called informing the Director of Nursing (DON) that Resident #91 had been found nearby. The notes revealed the officer stated Resident #91 was complaining of being dizzy and thirsty. The notes revealed the officer informed the DON the resident was being transferred to a nearby hospital for an evaluation. The notes revealed the physician was informed. The notes revealed the resident returned to the facility at approximately 3:00 PM with no other findings reported with instructions to resume the resident's current orders. The notes revealed a skin assessment was conducted upon return and revealed no signs of injury, bruising or skin breakdown. The notes revealed there was no pain or discomfort mentioned and the care plan was updated. The notes revealed under Nursing Intervention that the facility provided a 24-hour one-on-one sitter. Resident #91's eINTERACT Change in Condition Evaluation- V 5.1, dated 07/08/2024, completed by Registered Nurse (RN) #15, revealed Resident 91 was reported to have been walking in sunny hot weather outside the facility. The evaluation revealed Resident #91 complained of thirst, dizziness, and headache. The evaluation revealed Resident #91 was sent to the ED for further evaluation and treatment. The evaluation revealed the weather outside was 95 degrees with an excessive heat warning. The evaluation revealed Resident #91's family was notified. Resident #91's Order Summary Report with active orders as of 07/11/2024 revealed an order dated 07/10/2024, that stated Effective 7/8/2024 [07/08/2024] 1:1 sitter 24 hours every shift for elopement risk. An alert charting Progress Note *NEW*, dated 07/09/2024, revealed after Resident #91's return from the ED orders were received for 1:1 sitter for resident safety. During an interview on 07/10/2024 at 9:55 AM, Family Member (FM) #14, Resident #91's family member, stated that when family arrived at the facility to visit with Resident #91, the resident could not be found. FM #14 stated after a call to the DON, they were told of the situation and was informed they last saw the resident at 8:15 AM. FM #14 stated they called the DON back and was informed Resident #91 was found by a Police Officer and taken to the hospital by ambulance. FM #14 stated the resident was a walker and had always taken walks; when they walked, they picked up cans to recycle. During an interview on 07/10/2024 at 10:49 AM, the Social Services Director stated she was not told by the family that Resident #91 wandered and could be an elopement risk. During an interview on 07/10/2024 at 10:57 AM, Certified Nursing Aide (CNA) #9 stated Resident #91 always liked to walk around the building, but they would just go up and down the halls. She stated she had never seen Resident #91 attempt to leave. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056485	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arlington Gardens Care Center	3688 Nye Avenue Riverside, CA 92505

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/10/2024 at 11:14 AM, CNA #10 stated Resident #91 was confused and liked to walk around the halls of the building and liked to keep busy. CNA #10 stated she had seen Resident #91 on 07/08/2024 in the television room around 10:30 AM. She stated they are told during report to keep an eye out for residents if they like to wander and are told by the nurse if a resident was a wander risk. During an interview on 07/10/2024 at 11:16 AM, CNA #11 stated Resident #91 liked to walk up and down the hallways and usually walked with their spouse. CNA #11 stated staff would walk with the resident as well. She stated she never saw or heard of the resident trying to leave the building. She stated if a resident was a wander/elopement risk they were told by the nurses. During an interview on 07/10/2024 at 11:23 AM, LVN #5 stated she would see Resident #91 walking around the building and their family would take them outside to walk outside when they visited. LVN #5 stated the last time she saw Resident #91 on 07/08/2024 was in the television area near their room around 10:30 AM. During an interview on 07/10/2024 at 11:59 AM, CNA #12 stated Resident #91 would go outside with their family and walk around. CNA #12 said the last time she saw Resident #91 on 07/08/2024 was near their room in the television area between 10:00 AM and 11:00 AM. During an interview on 07/10/2024 at 1:06 PM, the DON stated she was told Resident #91 was unable to be located by their spouse a little before 12:00 PM on 07/08/2024. The DON stated staff were directed to look for Resident #91. The DON stated they were about to call the police when the police called them. The DON stated she asked the Police Officer to bring the resident back to the facility, but they informed her that the resident was being sent to the hospital. The DON stated she informed the residents spouse and FM #14. The DON stated she did speak with staff to determine when and how Resident #91 was able to leave the facility. According to the DON, she incorporated all of her interviews into her narrative in Resident #91's progress notes. She stated the interviews revealed Resident #91 was last seen near Station 2 around 10:00 AM on 07/08/2024. The DON stated that had never happened before; Resident #91 never tried to leave the building. She stated family did not inform the facility Resident #91 was a wander/elopement risk when they were admitted . The DON stated all the door alarms were checked; however, they had no idea what door the resident eloped from. During an interview on 07/10/2024 at 3:18 PM, RN #13 stated Resident #91 could be fidgety, and they would walk around a lot, but they had never tried to exit the facility. During an interview on 07/11/2024 at 8:56 AM, the Administrator stated there was never an issue with Resident #91 exiting the building. He stated he was never told Resident #91 was wandering and there was a risk of them eloping. He stated the security cameras were reviewed and it was discovered Resident #91 left the building twice the morning of 07/08/2024. He stated there was no camera footage of the doors Resident #91 left and entered from. On 07/11/2024 at 9:28 AM, a review of the facility security camera footage revealed Resident #91 walking around the exterior of the facility at approximately 8:25 AM on 07/08/2024, they exited out of an unknown door. Resident #91 then re-entered at an unknown time through an unknown door. Resident #91 was then seen walking around outside the facility at approximately 8:50 AM on 07/08/2024. They were not seen back in the facility until they were transferred back from their visit to the emergency room .

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 40141 Based on observation, interview, and facility policy review, the facility failed to ensure the daily direct care staffing was posted. This had the potential to affect all 98 residents that resided in the facility. Findings included: A facility policy titled, Posting Direct Care Daily Staffing Numbers, revised 07/2016, specified, Our facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. During an observation on 07/11/2024 at 12:29 PM, the surveyor was unable to locate the daily direct care staff posting. During an interview on 07/11/2024 at 1:53 PM, Certified Nurse Aide (CNA) #4 questioned what a daily direct care staff posting was and indicated the facility did not have a staff posting. During an interview on 07/11/2024 at 3:56 PM, the Administrator indicated he did not know the daily direct care staff posting was required to be posted. During an interview on 07/12/2024 at 11:08 AM, the Director of Nursing (DON) stated she realized the previous day that the daily direct care staffing was not posted, and it should have been posted. The DON stated CNA #4 did not know the staffing information should have been posted. The DON stated she expected the staff posting to be posted daily.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 40141 Based on observation, interview, record review, and facility policy review, the facility failed to maintain a medication error rate less than 5 percent (%) with a medication error rate of 7.69%. The facility had two medication errors out of 26 opportunities which affected 1 (Resident #29) of 4 residents observed for the medication administration task. Findings included: A facility policy titled, Administering Medications, revised 04/2019, indicated, Medications are administered in a safe and timely manner, and as prescribed. The policy revealed, 4. Medications are administered in accordance with prescriber orders, including any required time frame. An Admission Record indicated the facility admitted Resident #29 on 03/18/2019. According to the Admission Record, the resident had a medical history that included diagnoses of multiple sclerosis and immunodeficiency. Resident #29's Care Plan included a focus area initiated on 05/20/2024 that indicated the resident had a risk for constipation. Interventions directed staff to administer medications per physician order (initiated 05/20/2024). The Care Plan included a focus area initiated on 05/20/2024 that indicated the resident had a risk for malnutrition. Interventions directed staff to administer vitamin/minerals as ordered (initiated 05/20/2024). Resident #29's Order Summary Report with active orders as of 07/10/2024 revealed an order dated 05/19/2024 for Centrum (multiple vitamins with minerals) one tablet a day for supplement. The Order Summary Report revealed an order dated 05/19/2024 for docusate sodium 200 milligrams (mg) two times a day for bowel management. During an observation of medication pass on 07/10/2024 at 8:44 AM with Licensed Vocational Nurse (LVN) #5 revealed she prepared Resident #29's medications, including docusate sodium 100 mg and one multivitamin without minerals. During an interview on 07/10/2024 at 11:09 AM, LVN #5 retrieved a bottle of multivitamins without minerals with an expiration date of 08/2025 from the top drawer of the medication cart and stated it was the generic for a name brand vitamin. LVN #5 checked the physician order and indicated the order was for multivitamins with minerals. LVN #5 stated she administered the wrong medication, and Resident #29 should have received the multivitamin with minerals. During a follow-up interview on 07/10/2024 at 11:12 AM, LVN #5 checked the physician order for docusate sodium and stated she only gave 100 mg. LVN #5 stated she was nervous and did not give Resident #29 the right dose of docusate sodium. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/10/2024 at 3:59 PM, the Director of Nursing (DON) stated the process was to check the five rights for administering medication, which were verify the physician order for the medication and the dose, identification of the resident, and right route and right time. The DON stated she expected the correct dosage of medication to be administered and the correct multivitamin with minerals to be administered as ordered for Resident #29. During an interview on 07/11/2024 at 3:56 PM, the Administrator stated he expected medications to be administered as the physician ordered.