STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A137	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Park Behavioral Health Center	1425 Laurel Avenue Pomona, CA 91768

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50016 Based on observation, interview, and record review, the facility failed to obtain informed consents from the resident or the resident's responsible party for two of six sampled residents (Resident 7 and Resident 18) by failing to: A. Ensure the frequency (how many times per day and how often a medication is to be administered) of Clozapine (an antipsychotic medication [a drug used to treat serious mental health conditions]) was indicated in Resident 7's informed consent. B. Ensure an informed consent was obtained before increasing the dose of Olanzapine (an antipsychotic [main class of drugs used to treat people that have mental disorders like schizophrenia [mental disorder characterized by loss of contact with the environment]) medication, ordered for schizophrenia manifested by responding to internal stimuli (when someone exhibits behaviors that suggest they are perceiving or reacting to things that are not present in the external environment, often due to hallucinations [false perception of objects or events involving the senses] or delusions[a belief or altered reality that is persistently held despite evidence or agreement to the contrary]) for Resident 18. This deficient practice violated the resident's right to be fully informed and consent to receive psychoactive (mind altering drug that affects how the brain works, used to treat symptoms of psychosis [a collection of symptoms that affect the mind, where there has been some loss of contact with reality]) medications. Findings A. During a review of Resident 7's Admission Record (AR), the AR indicated the facility admitted Resident 7 on 12/28/2022 and readmitted the resident on 6/9/2024, with diagnosis including, schizophrenia, hypertension (HTN-high blood pressure), and type 2 diabetes mellitus (T2DM-a long term condition in which the body has trouble controlling blood sugar and using it for energy, can lead to poor wound healing). During a review of Resident 7's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/17/2024, the MDS indicated Resident 7's cognition (the ability to think and process information) was severely impaired. The MDS indicated Resident 7 was independent (resident completes the activity by self with no assistance from a helper) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and was independent with mobility. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 7's Medication Review Report, date range: 12/1/2024 to 12/31/2024, the report indicated a physician's order for Clozapine (medication used to treat schizophrenia) 150 mg (milligrams, unit of measurement) by mouth two times a day m/b [manifested by] responding to internal stimuli related to paranoid schizophrenia. During an interview and a concurrent record review on 12/19/2024 at 10:19 AM, with Licensed Psychiatric Technician (LPT) 1, Resident 7's Medication Administration Record (MAR) for the months of October 2024 through December 2024 were reviewed, the MARs indicated the following: - Resident 7 was administered Clozapine 150 mg PO [administered by mouth] twice daily starting on 10/24/2024 at 5 PM. LPT 1 stated the physician's order was active, and Resident 7 was taking Clozapine 150 mg as ordered. During an interview and a concurrent record review on 12/19/2024 at 10:19 AM, with LPT 1, Resident 7's Psychotropic Medication Administration Informed Consents were reviewed. The informed consent indicated the physician ordered Clozapine 150 mg PO for Schizophrenia manifested by responding to internal stimuli. LPT 1 stated informed consents must include medication, dosage, frequency, diagnosis, and manifestation as indicated on the form. LPT 1 stated the frequency of Clozapine was not included on the informed consent and Resident 7's informed consent was not accurately verified by LPT 1 and Registered Nurse (RN) 1. LPT 1 stated that informed consents ensured the person agreeing to a treatment was given all the information available including the risks, benefits, reasonable alternatives, and the consequences of not having the treatment. LPT 1 stated the form should be filled out accurately because it was a legal document and should include all the required information that's indicated on the form. During an interview and a concurrent record review on 12/19/2024 at 10:58 AM, with RN 1, Resident 7's Psychotropic Medication Administration Informed Consent was reviewed with RN 1. RN 1 stated that RN 1 recalled completing the informed consent form after the physician had obtained verbal consent from Resident 7's conservator (a person legally appointed by a court to manage the financial affairs and personal well-being of another person who is unable to do so themselves due to age, mental incapacity, or other reasons) for the use of the Clozapine. RN 1 stated RN 1 did not include the frequency for Clozapine and should have been included in the informed consent. RN 1 stated the informed consent was a legal document allowing the resident or conservator to make an informed decision about their treatment and protected the provider from potential legal issues by documenting the patient's awareness of the information provided. B. During a review of Resident 18's AR, the AR indicated the facility admitted Resident 18 on 4/6/2023, with diagnosis including, schizophrenia, hypertension, and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 18's MDS, dated [DATE], the MDS indicated Resident 18's cognition was intact. The MDS indicated Resident 18 was independent with activities of daily living and was independent with mobility. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 18's Order Recap (summary) Report, date range: 10/1/2024 to 10/31/2024, the report included a physician order dated, 10/23/2024, for Olanzapine 30 mg PO at bedtime related to schizophrenia. During a review of Resident 18's Order Summary Report, dated active as of 10/3/2024, the report indicated a physician's order dated 10/3/2023 for Olanzapine 25 mg PO [administered] at bedtime related to schizophrenia. During a review of Resident 18's MAR, dated 10/2024, the MAR indicated Resident 28 was administered Olanzapine 30 mg PO at bedtime related to schizophrenia starting on 10/24/2024. During an interview on 12/19/2024 at 10:19 AM, with LPT 1, LPT 1 stated that inform consents ensure that a person agreeing to treatment is given all the information available about risks, benefits, reasonable alternatives, and the consequences of not having the treatment. LPT 1 stated all residents taking psychotropic medications should have informed consents obtained by the physician prior to the administration of the mediation. During an interview and a concurrent record review on 12/19/2024 at 10:58 AM, with RN 1, Resident 18's informed consents since admission were reviewed with RN 1. RN 1 stated RN 1 was unable to find the informed consent indicating a dose increase of Olanzapine to 30mg for Resident 18. RN 1 stated the Resident 18's physician should have obtained an inform consent from the conservator when Olanzapine was increased from 25 mg to 30 mg. RN 1 stated the licensed nurses should verify that inform consents have been obtained prior to the administration of psychotropic medications. RN 1 stated informed consents were legal documents and allowed the resident (in general) or conservator to make informed decisions about their treatments while also protecting the provider from potential legal issues by documenting the patient's awareness of the information provided. During an interview on 12/19/2024 at 4:09 PM, with the Health Information Manager (HIM), the HIM stated the HIM was unable to obtain and provide the informed consent for the latest Olanzapine order that indicated the increase to 30 mg. The HIM stated it was more likely that it was not done. During a review of the facility's P&P titled, Guidelines for Charting and Documentation, dated 4/2012, the P&P indicated: A. The general rules for charting and documentation are to be concise, accurate, and complete and use objective terms. Avoid brief, monotonous, and meaningless entries. B. Content of Orders: specify the type, route, dosage, frequency, and strength of the medication ordered (i.e. , Dilantin 100 mg PO TID). During a review of the facility's P&P titled, Antipsychotic/Psychotropic Medication Use, dated 6/2021, the P&P indicated: a. Prior to the administration of antipsychotic/psychotropic medication the prescribing practitioner shall obtain informed consent and will be verified by a licensed nurse. b. facility shall verify informed consent prior to the administration of a psychotropic medication for a resident.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50016 Based on interview and record review, the facility failed to ensure two of two sampled residents (Resident 2 and Resident 15) were free from physical abuse (willful infliction of injury, deliberate aggressive or violent behavior with the intention to cause harm) as indicated in the facility's policy and procedure (P&P) titled, Abuse Prohibition Policy and Procedure, when on 12/11/2024 Resident 2 punched Resident 15 on the chest and Resident 15 pushed Resident 2 to the ground. This deficient practice resulted in physical abuse and had the potential to result in injury and harm to Resident 15 and Resident 2. Findings: During a review of Resident 2's Admission Record (AR), the AR indicated the facility admitted Resident 2 on 4/8/2011, and readmitted the resident on 5/28/2014, with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), moderate intellectual disabilities, and chronic (long standing) obstructive pulmonary disease (COPD-a common lung disease causing restricted airflow and breathing problems). During a review of Resident 2's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 11/7/2024, the MDS indicated Resident 2's ability to hear was adequate and Resident 2 had clear speech. The MDS indicated Resident 2's cognition (the ability to think and process information) was moderately intact, made self-understood, and was able to understand others. The MDS indicated Resident 2 was independent (resident completes the activity by themself with no assistance from a helper) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and was independent with mobility. During a review of Resident 15's AR, the AR indicated the facility admitted Resident 15 on 2/11/2020, with diagnoses including schizoaffective disorder (a mental illness that can affect your thoughts, mood, and behavior), hypertension (HTN-high blood pressure), and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 15's MDS, dated [DATE], the MDS indicated Resident 15's cognition was moderately intact. The MDS indicated Resident 15 was independent with ADLs and was independent with mobility. During a review of Resident 2's Progress Notes, dated 12/11/2024 timed at 11:50 AM, the progress notes indicated Resident 15 was in an altercation with another male peer [Resident 2] and Resident 15 called Resident 2 a boy, so Resident 2 punched Resident 15 in the chest and Resident 15 punched Resident 2 back in the chest and Resident 2 then fell to the ground. During a review of Resident 2's Confidential Adverse Incident Initial Reporting (CAR) Form, dated 12/15/2024, the CAR indicated the date of the incident was 12/11/2024. The CAR indicated Resident 2 reported Resident 2 hit Resident 15 because Resident 15 called Resident 2 a name. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's Interdisciplinary Care Conference form, dated 12/16/2024 timed at 9:23 AM, the IDT Care Conference notes indicated it was alleged that Resident 2 punched Resident 15 in the chest, then Resident 2 was pushed by Resident 15 and observed to fall to the ground. During an interview on 12/17/2024 at 09:07 AM, Resident 15 was unable to give a clear statement regarding the altercation with Resident 2. Resident 15 had disorganized and incoherent thoughts and stated, My shoes have wings, and they want me to fly to the moon, but [NAME] is trying to stop me. During an interview on 12/17/2024 at 10:27 AM, Resident 2 stated Resident 2 got upset and angry with Resident 15 for calling him a boy. Resident 2 stated Resident 2 punched Resident 15 on the chest and Resident 15 then pushed Resident 2 to the ground. Resident 2 pointed with his finger at the corridor next to the dining facility where the incident occurred. Resident 2 was unable to state when the incident occurred. During an interview on 12/17/2024 at 10:44 AM, with Certified Nursing Assistant (CNA) 1, CNA 1 stated that CNA 1 was working at the facility on 12/11/2024 the day of the altercation between Resident 2 and Resident 15. CNA 1 stated CNA 1 was inside the [NAME] unit looking for a resident at that time. CNA 1 stated the [NAME] unit was located near the corridor where the altercation occurred. CNA 1 stated Resident 15 and Resident 2 didn't show any signs of aggressiveness, anger, or impulsive behaviors the morning of 12/11/2024. CNA 1 stated Resident 2 was generally calm and tended to keep to himself. CNA 1 stated Resident 15 tended to get restless when too many people were around or got agitated when Resident 15 didn't get what Resident 15 wanted. CNA 1 stated CNA 1 didn't see what led to the altercation and only caught the tail end (the last part of something) of the incident. CNA 1 stated CNA 1 saw Resident 2 on the ground and Resident 15 fleeing the scene in a fast pace. CNA 1 stated Resident 2 reported Resident 15 called Resident 2 a boy and that made Resident 2 upset and angry causing Resident 2 to punch Resident 15 in the chest, which then led Resident 15 to push Resident 2 to the ground. CNA 1 stated Resident 8 witnessed the incident and told CNA 1 Resident 2 threw a punch at Resident 15 and Resident 15 pushed Resident 2 to the ground. CNA 1 stated residents (in general) in the facility should be monitored consistently for their safety, well-being, and progress in treatment. During an interview on 12/17/2024 at 1:48 PM, with the Administrator (ADM), the ADM stated the ADM conducted the 5-day follow-up report investigation. The ADM stated the ADM had two witnesses CNA 1 and Resident 8. The ADM stated CNA 1 witnessed Resident 2 on the ground and did not witness what started the altercation. The ADM stated Resident 8 stated, a black guy pushed a white guy and then he gave the middle finger and walked away. The ADM stated when CNA 1 asked Resident 2 what happened Resident 2 walked away, then Resident 2 reported Resident 2 hit Resident 15 because Resident 15 called him a name. The ADM stated Resident 15 never gave his statement, denied doing anything. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/19/2024 at 9:47 AM, with Licensed Psychiatric Technician (LPT) 1, LPT 1 stated LPT 1 was working on 12/11/2024 the day of the altercation between Resident 2 and Resident 15. LPT 1 stated the altercation was around noon during medication administration time. LPT 1 stated LPT 1 was in the nursing station administering residents' medication. LPT 1 stated Resident 2 came up to the nursing station for his medication and LPT 1 did not notice any signs of aggressiveness, agitation, irritable or delusional (a belief or altered reality that is persistently held despite evidence or agreement to the contrary) behavior. LPT 1 stated LPT 1 didn't notice any signs of aggressiveness, agitation, anxious or delusional behavior with Resident 15. LPT 1 stated LPT 1 did not witness the altercation until staff members notified LPT 1. LPT 1 stated staff were occupied around noon because of medication administration and prepping for lunch distribution. LPT 1 stated continuous monitoring was the cornerstone of effective care in behavioral facilities, ensured residents received the support they needed to recover and thrive in a safe and structured environment. During an interview on 12/20/2024 at 10:12 AM, with Registered Nurse (RN) 1, RN 1 stated that she wasn't working on 12/11/2024 the day of the altercation between Resident 2 and Resident 15. RN 1 stated that Resident 15 typically wasn't aggressive or angry and stated Resident 15 was respectful, responded to commands, and was easily redirectable. RN 1 stated Resident 2 typically wasn't aggressive or angry and was respectful too. RN 1 stated Resident 2 got angry at times when Resident 2 was anxious. RN 1 stated Resident 2 responded better to staff Resident 2 was familiar with but Resident 2 opened up once Resident 2 got to know the staff. RN 1 stated careful supervision of residents ensured safety, timely intervention, created a safe environment, and encouraged healthy behaviors which ultimately enhanced resident outcomes. During a review of the facility's P&P titled, Abuse Prohibition Policy and Procedure, review date 2/23/2021, the P&P indicated: Healthcare Centers prohibit abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all residents. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the patient's medical symptoms. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, injury, or mental anguish. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical abuse includes hitting, slapping, pinching, kicking, etc., as well as controlling behavior through corporal punishment. To ensure that Center staff are doing all that is within their control to prevent occurrences of abuse, mistreatment, neglect, exploitation, involuntary seclusion, injuries of unknown source, and misappropriation of property for all patients. The Center will provide adequate supervision when the risk of resident-to-resident altercation is suspected.

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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. 50016 Based on interview and record review, the facility failed to ensure the assessment entry in the general (refers to the initial observation of the patient's overall appearance, including their level of comfort, posture, hygiene, skin color, and any noticeable physical characteristics) section on a physical and history (H&P) exam was accurately documented to reflect the Resident's ability to hear and verbalize with others for one of one sampled resident (Resident 2). This deficient practice had the potential to negatively affect Resident 2's plan of care and delivery of necessary care and services. Findings: During a review of Resident 2's Admission Record (AR), the AR indicated the facility admitted Resident 2 on 4/28/2011 and readmitted the resident on 5/28/2014 with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), moderate intellectual disabilities, and chronic (long standing) obstructive pulmonary disease (COPD-a common lung disease causing restricted airflow and breathing problems). During a review of Resident 2's History and Physical (H&P), dated 10/22/2024, the H&P indicated Resident 2 was nonverbal, deaf, and used sign language. The H&P indicated Resident 2 could not make own decisions but could make needs known. The H&P indicated Nurse Practitioner 1 (NP 1) spoke with Resident 2 and Resident 2 verbally agreed to receive chronic care management services. During a review of Resident 2's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 11/7/2024, the MDS indicated Resident 2's ability to hear was adequate and Resident 2 had clear speech. The MDS indicated Resident 2's cognition (the ability to think and process information) was moderately intact. The MDS indicated Resident 2 was independent (resident completes the activity by themself with no assistance from a helper) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and was independent with mobility. During an observation and concurrent interview on 12/18/2024 at 12:34 PM, with Resident 2, Resident 2 was observed verbally communicating with other residents in the patio during lunch time. Resident 2 stated Resident 2 was able verbally respond without any difficulty and denied having hearing problems. During a phone interview and concurrent record review on 12/20/2024 at 12:56 PM, with NP 1, Resident 2's H&P was reviewed. The NP 1 stated NP 1 the information regarding Resident 2 documented on the H&P [nonverbal, deaf, and used sign language] in error and NP 1 mixed up Resident 2 with another resident. The NP 1 stated NP 1 saw many residents on 10/22/2024 and documented Resident 2 was nonverbal, deaf, and used sign language in error. The NP 1 stated the H&P should be accurately completed because it provided the foundation for proper diagnosis and treatment, gave healthcare providers a comprehensive understanding of a patient's health condition, and allowed them to tailor care plans, identify potential risks, and make informed decisions to achieve the best possible patient outcomes. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/20/2024 at 1:07 PM, with Registered Nurse (RN) 2, RN 2 stated inaccurate assessments could lead to misdiagnoses, inappropriate treatments, and potentially harmful consequences for the patient. RN 2 stated clinicians should ensure H&P exams were accurate because they provided critical information about a person's general physical health, possible diseases, and progress toward recovery. During a review of the facility's P&P titled Guidelines for Charting and Documentation, revision dated 4/2012, the P&P indicated the general rule for charting and documentation was to be concise, accurate, and complete and use objective terms. the P&P indicated to avoid brief, monotonous, and meaningless entries. During a review of the facility's P&P titled, Resident Assessments, revision dated 10/2023, the P&P indicated assessments are completed by staff members who have these skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's strengths and areas of decline.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 50016 Based on observation, interview, and record review, the facility failed to develop and implement an individualized person-centered plan of care (care plan, CP) that included measurable objectives, timeframes, and interventions that met resident needs for two of two sampled residents (Resident 17 and Resident 24) by failing to: A. Develop a CP for Resident 17 in a timely manner to address Resident 17's refusal of the front wheel walker (FWW, a mobility device with two wheels in the front and two glide caps in the back that's used to help people with limited mobility walk and transfer) after several falls. B. Implement goals and care interventions in a timely manner to address Resident 24's need for supervision during smoking breaks. These deficient practices had the potential to result in unmet individualized needs for Resident 24 and the potential to affect the resident's physical and psychosocial well-being and negatively affect Residents 17 and 24. Findings A. During a review of Resident 17's Admission Record (AR), the AR indicated the facility admitted Resident 17 on 10/3/2019, with diagnosis including, schizophrenia (a mental illness that is characterized by disturbances in thought), anemia (a condition where the body does not have enough healthy red blood cells), and pain in the leg. During a review of Resident 17's Change in Condition Evaluation, dated 7/8/2024, timed at 9 AM, the evaluation indicated Resident 17 had a fall on 7/8/2024 and the fall was associated with no or minor injury. During a review of Resident 17's CP, revision date 7/10/2024, the CP indicated Resident 17 was as risk for falls. The CP indicated Resident 17's latest fall was on 7/8/2024 without injury. The latest intervention of the CP was initiated on 7/17/2024 and indicated Resident 17 may always use a walker for ambulation (walking). During a review of Resident 17's Physical Therapy Evaluation, dated 7/16/2024, indicated Resident 17's treatment plan was the need of a FWW as a fall prevention measure. During a review of Resident 17's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 12/19/2024, the MDS indicated Resident 17 cognition (the ability to think and process information) was intact. The MDS indicated Resident 17 was independent (resident completes the activity by themself with no assistance from a helper) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and was independent with mobility. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 17's Medication review Report, active orders with date range 12/1/2024 to 12/31/2024, the report indicated a physician's order dated 7/8/2024 for approval of physical therapy (PT) evaluation for Resident 17 to assess the potential benefit of a walker to help prevent further falls. During an observation and a concurrent interview on 12/18/2024 at 10:31 AM, Resident 17 was observed in the patio taking short steps, swaying side to side during occasional steps, and was not using a FWW. Resident 17 stated Resident 17 refused to use the walker because it made Resident 17 feel old. Resident 17 stated Resident 17 understood that Resident 17 should be using the walker to prevent from falling. During an interview and a concurrent record review on 12/19/2024 at 09:47 AM, with Licensed Psychiatric Technician (LPT) 1, Resident 17's CPs were reviewed. LPT 1 stated Resident 17 did not have a CP that addressed Resident 17's refusal of the FWW. LPT 1 stated Resident 17 had a history of falls without major injuries. LPT 1 stated Resident 17 also had the tendency of placing herself on the floor and hadn't had a fall since 7/8/2024. LPT 1 stated the physician ordered a PT evaluation after Resident 17's last fall to evaluate for the need and benefit of a walker. LPT 1 stated PT recommended the use of the walker and educated Resident 17 on how to use the walker. LPT 1 stated Resident 17 had a physician's order for the walker, however, Resident 17 often refused to use it. LPT 1 stated the facility didn't CP the refusal of the walker and should have care planned it. LPT 1 stated care planning the refusal helped the facility develop different strategies to address the concern of the falls for Resident 17 and could potentially improve Resident 17's outcome. During an interview on 12/20/2024 at 10:30 AM, with Registered Nurse (RN) 1, RN 1 stated the facility should have care planned Resident 17's refusal of the FWW because it was the treatment plan to prevent falls. RN 1 stated care planning the refusal of the FWW helped focus on understanding the reasons behind Resident 17's refusal and provided alternative goals and interventions to address the fall risk concern while respecting the resident's autonomy. B. During a review of Resident 24's Admission Record (AR), the AR indicated the facility admitted Resident 24 on 3/1/2023, with diagnosis including, schizophrenia, hypertension (HTN-high blood pressure), and Gastroesophageal Reflux Disease (GERD- a condition where stomach contents leak back into the esophagus, or food pipe, irritating the lining of the esophagus). During a review of Resident 24's Smoking Evaluation, dated 3/9/2024, the evaluation indicated Resident 24 required smoking supervision per the facility's policy and did not have the ability to light a cigarette. During a review of Resident 24's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 12/11/2024, the MDS indicated Resident 24's cognition was moderately impaired. The MDS indicated Resident 24 was independent (resident completes the activity by themself with no assistance from a helper) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and was independent with mobility. During a review of Resident 24's medical record on 12/17/2024 at 3:49 PM, there was no smoking CP in the medical record. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and a concurrent record review on 12/18/2024 at 1:02 PM, with Registered Nurse (RN) 2, Resident 24's CPs were reviewed with RN 2. RN 2 stated Resident 24's CPs did not include a smoking CP. RN 2 stated all residents who smoked at the facility should have a smoking CP. RN 2 stated smoking CPs ensured interventions for the resident's safety were in place, such as the proper handling of cigarettes, smoking expectations, compliance with the smoking policy, and smoking cessation education. RN 2 stated monitoring smoking interventions helped the staff determine if the smoking CP needed modification or an adjustment based on the resident's compliance and safety. During an interview on 12/20/2024 at 3:17 PM, with RN 3, RN 3 stated nursing CPs were patient-centered, and they promoted collaboration, compliance, and continuity of care. RN 3 stated all residents who smoked should have a CP, this ensured resident safety, smoking compliance to facility's policy, and education on smoking cessation. RN 3 stated that CPs ensured staff provided quality care and ensured interventions were being executed. During a review of the facility's P&P titled, Smoking, dated 8/9/2022, the P&P indicated that the Interdisciplinary Team (IDT) will develop and individualized plan for safe storage, use of smoking materials, assistance and required supervision, if necessary, for residents who smoke. This is documented on the Resident Smoking Evaluation, the residents Plan of Care, and discussed with the resident and Responsible Party at resident care conference meetings. During a review of the facility's P&P titled, Care Plan Comprehensive, effective date 8/25/2021, the P&P indicated that an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, physical, mental, and psychosocial needs shall be developed for each resident. The P&P indicated assessments of residents are ongoing and care plans are reviewed and revised as information about the resident and the resident's condition change. The P&P indicated each resident's comprehensive care plan is designed to: 1. Build on Resident's individualized needs, strengths, and preferences. 2. Reflect the resident's expressed wishes regarding care and treatment goals.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 50016 Based on interview, and record review, the facility failed to update a care plan (CP) and include new interventions, for one of two sampled residents (Resident 36), after Resident 36 sustained a fall on10/30/2024 and as indicated in the facility's policy and procedure titled, Care Plan Comprehensive, and Fall Management. This deficient practice had the potential to result in unmet individualized needs for Resident 36 and the potential to affect the resident's physical and psychosocial well-being. Findings: During a review of Resident 36's Admission Record (AR), the AR indicated the facility admitted Resident 36 on 3/26/2024, with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought) and psychoactive (altering the mind or consciousness) substance abuse. During a review of Resident 36's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 10/1/2024, the MDS indicated Resident 36's cognition (the ability to think and process information) was moderately intact. The MDS indicated Resident 36 was independent (resident completes the activity by themself with no assistance from a helper) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and was independent with mobility. During a review of Resident 36's At Risk for Falls CP, initiated 5/3/2024, the interventions in the CP indicated the facility would obtain and evaluate orthostatic blood pressure (the measurement of blood pressure taken when a person stands up from a lying or sitting position) and provide verbal cues for safety and sequencing when needed. During a review of Resident 36's Interdisciplinary Care Conference report dated 10/31/2024, the report indicated Resident 36 had a fall on 10/15/2024 at 7:40 AM. During a review of Resident 36's Interdisciplinary Care Conference report dated 10/30/2024, the report indicated that Resident 36 had a fall on 10/30/2024 at 7:40 AM. During an interview on 12/17/2024 at 9:45 AM, with Resident 36, Resident 36 stated Resident 36 had two recent falls at the facility but Resident 36 could not recall exactly when the falls occurred. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent record review on 12/19/2024 at 9:47 AM, with Licensed Psychiatric Technician (LPT) 1, the At Risk for Falls CP dated 5/3/2024, was reviewed with LPT 1. The interventions in the CP indicated the facility would monitor for headaches, vomiting, or worsening symptoms and monitor Resident 36 for any changes and continue with q15 (a safety check occurring every 15 minutes) monitoring. LPT 1 stated Resident 36's At Risk for Falls CP was initiated on 5/3/2024. LPT 1 stated the CP for At Risk for Falls was not updated to include new interventions after Resident 36 had a fall 10/30/2024. LPT 1 stated At Risk for Falls CPs should be updated to include new interventions after each fall to prevent further falls that could potentially lead to injury. LPT 1 stated interventions should be added to At Risk for Falls CPs whenever there was a change in the resident's condition, behavior, environment, or risk factors, to ensure the CPs remained effective in preventing falls and addressed the specific needs of the residents (in general). During an interview on 12/20/2024 at 9:57 AM, with Registered Nurse (RN) 1, RN 1 stated staff should always update At Risk for Falls CPs after a fall occurred [to include new interventions]. RN 1 stated a fall was a significant change in a resident's condition and updating the CP with new interventions allowed the facility to identify the causes of the fall, implement new interventions to address those specific risk factors, and minimized the chances of future falls by tailoring the plan to the individual's unique needs based on the incident. RN 1 stated updating the CP promptly and effectively helped reduce the risk of future falls and ensured resident safety and well-being. During a review of the facility's P&P titled, Care Plan Comprehensive, revision dated 8/25/2021, the P&P indicated: A. Assessments of residents are ongoing and care plans are reviewed and revised as information about the resident and the resident's condition changes. B. The Interdisciplinary Team (IDT) is responsible for evaluation and updating of care plans: 1.When there has been a significant change in resident's condition. 2.When the desired outcome is not met. 3.When the resident has been readmitted to the facility from a hospital stay; and 4.At least quarterly. During a review of the facility's P&P titled, Fall Management, dated 5/26/2021, the P&P indicated if patient falls update care plan to reflect new interventions.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50016 Based on interview and record review, the facility failed treatments and services were provided for two of two sampled residents (Resident 24 and Resident 39) as indicated in the facility policy and procedure (P&P) titled, Physician Order, and Medication Ordering and Receiving from Pharmacy, when, A. The facility failed to follow a physician's order from 2/2024 to 12/2024 for Resident 24, that indicated orthostatic blood pressure ([OBP], the measurement of BP taken when a person stands up from a lying or sitting position. The person lies down for at least five minutes, the BP and pulse are measured while lying or sitting, then the person stands up and the measurement is repeated after one and three minutes. The purpose is to compare the BPs taken in both positions and look for a significant drop in BP upon standing which would indicate orthostatic hypotension [low BP]) was to be taken . B. The facility failed to re-order Resident 39's Propranolol (medication used to treat severe restlessness, and agitation) and Resident 39 missed five doses of the medication. These deficient practices resulted in an incorrect treatment due to no measurements of OBPs for Resident 24 and had the potential to result in physical declines to Residents 24 and 39. Findings: A. During a review of Resident 24's Admission Record (AR), the AR indicated the facility admitted Resident 24 on 3/1/2023, with diagnosis including, schizophrenia (a mental illness that is characterized by disturbances in thought), hypertension (HTN-high blood pressure), and Gastroesophageal Reflux Disease (GERD- a condition where stomach contents leak back into the esophagus, or food pipe, irritating the lining of the esophagus). During a review of Resident 24's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 12/11/2024, the MDS indicated Resident 24's cognition (the ability to think and process information) was moderately impaired. The MDS indicated Resident 24 was independent (resident completes the activity by themself with no assistance from a helper) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and was independent with mobility. During a review of Resident 24's Medication Review Report, dated active as of 12/18/2024, the report included a physician's order, dated 3/1/2023, the order indicated to monitor orthostatic BP while lying/sitting/standing, one time a day starting on the 15th and ending on the 15th of every month. During a review of Resident 24's Weights and Vitals Summary (VSS, the basic measurements of your body's functions, like your temperature, heart rate (pulse), breathing rate, and blood pressure), dated 2/2024 to 12/2024, the VSS did not indicate OBPs were taken for Resident 24 from 2/2024 to 12/2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and a concurrent record review on 12/17/2024 at 2:31 PM, with Registered Nurse (RN) 1, Resident 24's VSS was reviewed with RN 1. RN 1 stated OBPs were not carried out as the physician order indicated. RN1 stated RN 1 could not identify any records indicating OBPs for Resident 24 were performed. RN 1 stated if OBPs were not documented, they were not performed. RN 1 stated physician orders must be followed, if not followed, it could impact the patient's safety. RN 1 stated carrying out physician orders ensured the correct treatment plan was followed and failure to do so could lead to potential complications for the resident. During an interview on 12/20/2024 at 3:17 PM, with RN 3, RN 3 stated maintaining patient safety relied significantly on clear and carefully reviewed physician orders by the nurses, which could prevent errors. RN 3 stated carrying out physician orders was the standard of care and was essential for delivering the correct treatment plan, which ultimately impacts the patient's well-being. RN 3 stated not following the physician orders led to potential harm and problems for the residents. During a review of the facility's P&P titled, Physician Order, dated 8/9/2022, the P&P indicated: 1.The purpose of the policy was to ensure that all physician orders are complete and accurate. 2.The Medical Records Department would verify that physician orders were complete, accurate and clarified as necessary. 3.Documentation pertaining to physician orders will be maintained in the resident's medical record. 48729 B. During a review of Resident 39's AR, the AR indicated Resident 39 was admitted to the facility on [DATE] with multiple diagnoses including schizophrenia and drug induced akathisia (a feeling of restlessness and distress that can be caused by various medications) During a review of Resident 39's MDS, dated [DATE], indicated Resident 39 had intact cognition and was independent for eating, toileting, and hygiene. During a review of Resident 39's Medication Administration Record (MAR) dated 12/1/2024 to 12/31/2024, the MAR indicated to give Propranolol 20 milligrams (mg, unit of weight) by mouth three times a day with start date 10/2/2024. The MAR indicated NN on the following days and times: 1. 12/13/2024 at 4:30 PM 2. 12/16/2024 at 6:30 AM and 4:30 PM 3. 12/17/2024 at 6:30 AM and 11:30 AM The MAR indicated NN = No/ See Nurse Notes. During a review of Resident 39's Progress Notes (PN) dated 12/13/2024 at 4:23 PM, 12/16/2024 at 6:22 AM, 12/16/2024 at 4:11 PM, 12/17/2024 at 7:35 AM, and 12/17/2024 at 12:54 PM, the PNs indicated Propranolol was not available. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/18/2024 at 2:35 PM with Licensed Psychiatric Tech (LPT) 1, LPT 1 stated some medications were automatically ordered on cycles while others had to be manually re-ordered from the pharmacy. LPT 1 stated staff usually re-ordered medications when the amount equaled a five-day supply. During an interview on 12/19/2024 at 2:40 PM with RN 1, RN 1 stated Resident 39's Propranolol should have been re-ordered on 12/13/2024 when it was first identified that the medication was unavailable. RN 1 stated Resident 39 was taking the medication for drug induced akathisia which could cause abnormal movements. RN 1 stated without the medication, Resident 39 might not be able to relax Resident 39's body and the resident could potentially become anxious, and it could be detrimental to Resident 39's mental health. During an interview on 12/20/2024 at 9:58 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated LVN 1 could not find documentation indicating when Resident 39's Propranolol was re-ordered, or which nurse re-ordered the medication. LVN 1 stated if the medication was re-ordered, this would be found in the progress notes but there was no note indicating when the medication was ordered. LVN 1 stated it was important to document when a medication was re-ordered to have good communication with staff and to be able to follow up with the pharmacy if there was a delay. LVN 1 stated it was also important to re-order and document so that staff could monitor the resident for behaviors as needed if the medication was not able to be filled in time. During a telephone interview on 12/20/2024 at 11:14 AM with Pharmacy Technician (PT), the PT stated pharmacy records showed the facility requested a refill for Resident 39's Propranolol on 12/17/2024 and it was delivered the same day. During a review of the facility's P&P titled, Medication Ordering and Receiving from Pharmacy, dated 2/2022, the P&P indicated, to reorder medication five days in advance of need to assure an adequate supply was on hand.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 48729 Based on interview and record review the facility failed to evaluate and ensure one of four Certified Nursing Assistants (CNA 3) had completed annual skills training. This failure had the potential to result in unsafe resident care. Findings: During a concurrent interview and record review on 12/20/2024 at 12:25 PM with Director of Staff Development (DSD), CNA 3's employee file and Employee Orientation IMD Checklist, (EOIC) dated 5/2/2023 was reviewed. The EOIC indicated CNA 3 was hired on 5/2/2023 and CNA 3 completed trainings on 5/2/2023, 5/3/2023 and 5/5/2023. The DSD stated skills training needed to be updated annually to ensure staff was update for any changes and ensure safety and care were done correctly. The DSD stated the DSD did not see any documentation indicating skills training was completed by CNA 3 in 2024. The DSD stated CNA 3 should not have cared for residents until CNA 3's skills trainings were up to date. During a review CNA 3's Timecard, (TC) dated from 11/01/2024 to 12/16/2024, the TC indicated CNA 3's most recent days of work were 12/7/2024 11:12 PM through 12/8/2024 7:12 AM and on 12/8/2024 11:20 AM through 12/9/2024 7:07 AM. During a review of the facility's assignment sheet titled, L.P. Assignments - Nursing Direct Care NOC, (LPA) dated 12/7/2024 and 12/8/2024, the LPA indicated CNA 3 had direct patient care on these days. During a review of the facility's policy and procedure (P&P) titled, In-service Training, All Staff, dated 8/2022, the P&P indicated all staff must participate in initial orientation and annual in-service training.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 48729 Based on interview and record review, one of one facility (the facility) failed to ensure a full-time Director of Nursing (DON) was employed by the facility. This failure had the potential to lead to a lack of oversight of the facility's nursing practices and effect the care provide to the residents residing at the facility. Findings: During an interview on 12/17/2024 at 8:41 AM with the Administrator (ADM), the ADM stated currently, the facility had no DON, and the DON role was being filled by multiple Registered Nurses (RNs). During an interview on 12/20/2024 at 10:45 AM with Registered Nurse (RN) 1, RN 1 stated it was important to have a DON onsite because the DON generally had more knowledge, training, and experience and could handle oversight of resident treatments and medications correctly. During a review of the facility's offer of employment letter, dated 12/11/2024, the letter indicated the full-time position for DON would start 12/23/2024. The letter indicated a signature on the returned copy and verified acceptance of the position. The letter indicated the potential DON's signature on the bottom portion. During a review of the facility's policy and procedure (P&P) titled, Director of Nursing Services (DNS), undated, the P&P indicated the director was employed full time (40-hours per week) and was responsible for but was not necessarily limited to: b. overseeing standards of nursing practice.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 45553 Based on observation, interview, and record review, the facility failed to ensure proper disposal (discarding of medications) of drugs (medications), for three of three sampled residents (Residents 7, 8, and 13), as indicated in the facility's Policy and Procedure (P&P) titled, Disposal of Medications and Medication-Related Supplies, when, 1. On 12/18/2024, three blister packs (a tamper-evident packaging where individually sealed tablets are pushed through foil to dispense the medication) of expired antibiotic (medications that fight bacterial infections) medications were found in the medication cart. This deficient practice had the potential to result in the accidental use of ineffective antibiotic medications and the potential to result in bacterial growth and physical declines to Residents 7, 8, and 13. Findings: On 12/18/2024 at 8:37 AM, during a Medication Cart inspection in Nursing Station 1 with Registered Nurse 2 (RN 2) and Licensed Psychiatric Technician 1 (LPT 1), there were three blister packs of antibiotic medications. The packs indicated the following antibiotic medications and expiration dates, - For Resident 7, Sulfamethoxazole 800 mg (milligram, unit of measurement)-Trimethoprim 160 mg tablet (combination of two antibiotics, used to treat a wide variety of bacterial infections), expiration date: 12/2/2024. - For Resident 8, Amoxicillin 500 mg capsules (used to treat bacterial infections, such as chest infections [including pneumonia] and dental abscesses [pocket of pus]), expiration date: 12/16/2024. - For Resident 13, Amoxicillin 500 mg capsules with expiration date: 12/16/2024. During a review of the facility's record titled, Medication Disposition Record/Pass Log, on 12/18/2024, the log indicated and confirmed the following antibiotic medications were expired for Residents 7, 8, and 13: 1. Resident 7 - Sulfamethoxazole 800 mg-Trimethoprim 160 mg tablet; fill date: 6/5/24; quantity filled: 20; quantity disposed: 13; method of disposition, waste management; expiration date: 12/2/24; disposition (discarding of medications) date: 12/18/24. The log indicated two signatures from RN 2 and LPT 1. 1. Resident 8 - Amoxicillin 500 mg capsule, fill date: 6/19/24; quantity filled: 21; quantity disposed: 1; method of disposition: waste management; expiration date: 12/16/24; disposition date: 12/18/24; 2 signatures: 2 signatures: RN 2 and LPT 1. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident 13 - Amoxicillin 500 mg capsule; fill date: 6/19/24; quantity filled: 21; quantity disposed: 1; method of disposition: waste management; expiration date: 12/16/24; disposition date: 12/18/24; 2 signatures: RN 2 and LPT 1. During a concurrent interview and review of the facility's medication disposal log with RN 2 and LPT 1 on 12/18/2024 at 8:46 AM, RN 2 and LPT 1 stated they [the facility] used a log located in a white binder to record expired medications. RN 2 and LPT 1 stated their signatures were on the log and indicated expired medications for Residents 7, 8, and 13. The expired medications were disposed on 12/18/24. During a concurrent interview and review of the facility's medication disposal log with RN 2 on 12/19/2024 at 11:03 AM, RN 2 stated disposal of expired medications were placed in a locked bin. RN 2 stated no blister packs with expired medications were to be kept with current medications (not expired) in the medication cart. RN 2 stated all expired medications should be removed from the blister packs and individually disposed of and placed in the locked bin. During a review of the facility's P&P titled, Disposal of Medications and Medication-Related Supplies, dated October 2017, the P&P indicated, Discontinued medications and medications left in the facility after a resident's discharge, which do not quality for return to the pharmacy for credit, are destroyed. The P&P indicated the medication is destroyed within 90 days from the date the medication [is] discontinued.

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	05A137	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Park Behavioral Health Center	1425 Laurel Avenue Pomona, CA 91768

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48729 Based on interview and record review, the facility failed to adequately monitor one of five sampled resident's (Resident 40) use of psychotropic (drug or substance that changes mood, awareness, thoughts feelings or behavior) medication haloperidol (medication used to treat nervous, emotional, and mental conditions) as evidenced by failure to limit PRN (as needed) haloperidol to 14 days per the facility's policy and procedure (P&P) and failure to monitor Resident 40's anxious behavior and side effects of haloperidol. This failure had the potential to result in Resident 40 to experience adverse (unwanted) effects of haloperidol. Findings: During a review of Resident 40's Admission Record, (AR), the AR indicated Resident 40 was admitted to the facility on [DATE] with multiple diagnoses schizoaffective disorder, bipolar type (a mental illness that can affect thoughts, mood, and behavior) and anxiety disorder (condition in which a person has excessive worry and feelings of fear, dread, and uneasiness.) During a review of Resident 40's Minimum Data Set (Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 10/4/2024, indicated Resident 40 had intact cognition (ability to reason, think, plan) and was independent for eating, toileting, and hygiene. During a concurrent interview and record review on 12/19/2024 at 2:58 PM with Registered Nurse (RN) 1, Resident 40's Medication Administration Record (MAR) dated 12/1/2024 to 12/31/2024 was reviewed. The MAR indicated to administer haloperidol 5 milligrams (mg - unit of weight) by mouth every six hours as needed for anxiety. RN 1 stated there was no end date on Resident 40's order for Haloperidol but the order should be limited to 14 days per the pharmacy. RN 1 stated without an end date in the order it would be possible to administer the medication past the intended 14-day limit. When asked how Resident 40's anxiety manifested, RN 1 stated Resident 40 paced and fidgeted and verbalized when Resident 40 felt anxious. RN 1 stated other staff may not know Resident 40's anxious behavior and RN 1 knew Resident 40's behavior from RN 1's own assessment of the resident. The MAR did not indicate side effects for the use of haloperidol or Resident 40's anxious behaviors were being monitored. During a concurrent interview and record review on 12/20/2024 at 10:17 AM with Licensed Vocational Nurse (LVN) 1, Resident 40's physician order for haloperidol with a start date of 12/17/2024 was reviewed. The order indicated, haloperidol 5 mg tablet, one tablet administered by mouth every 6 hours as needed for anxiety. LVN 1 stated Resident 40's order for haloperidol should have included the manifestation of Resident 40's anxiety and how many days the order was valid for. LVN 1 stated the behavior and duration of the order should be included so staff understood what the medication was for and help get Resident 40 back to their baseline and stabilize their mood. LVN 1 stated it was important to monitor for potential side effects of haloperidol. LVN 1 stated, side effects were currently not monitored for the administration of haloperidol to Resident 40. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, dated 6/2021, the P&P indicated PRN orders for psychotropic drugs are limited to 14 days. The P&P further indicated all medications used to treat behaviors must have a clinical indication and should be monitored for: efficacy, risks, benefits, harm or adverse (unwanted) consequences. During a review of the facility's P&P titled, Antipsychotic/ Psychotropic Medication Use, undated, the P&P indicated nursing staff shall monitor for and report any side effects and adverse consequences of antipsychotic medications to the Attending Physician.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45553 Based on observation, interview, and record review, the facility failed to ensure foods were labeled in one of one kitchen (Kitchen 1) when: 1. A bowl, wrapped in plastic, was observed in the reach-in refrigerator, and the bowl was not dated. This deficient practice had the potential to result in foodborne illness (illness caused by food contaminated with bacteria) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever for the residents residing at the facility. Findings: On 12/17/2024 at 9:01 AM, during a Kitchen tour, one Styrofoam bowl wrapped in plastic was observed in the reach-in refrigerator. Inside the bowl there was a white substance, and the bowl or wrapping were not dated. The words [NAME] no eggs toast were handwritten with black marker on the plastic wrapping. During a concurrent interview and observation with the [NAME] on 12/17/2024 at 9:06 AM, the [NAME] stated the bowl wrapped in plastic had cottage cheese in it, and the cottage cheese was for a resident's (unidentified) breakfast this morning. The [NAME] stated the resident did not want the bowl for breakfast. The [NAME] stated all food in the refrigerator should be labeled with the name of the item, the date of preparation, and the date of expiration. The [NAME] stated food with an unknown date of preparation or unknown date of expiration could cause a resident (in general) to become sick with a foodborne illness if the food was consumed. During a review of the facility's Policy and Procedure (P&P) titled, Healthcare Services Group (HCSG) Policy 019: Food Storage - Cold Foods dated February 2023, the P&P indicated, Policy Statement: All Time/Temperature Control for Safety (TCS) foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines for the U.S. Food and Drug Administration (FDA) Food Code. Procedures: All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 48729 Based on interview and record review, one of one facility (the facility) failed to have all required members of the Quality Assessment and Assurance committee present by not having an employed Director of Nursing (DON). This failure had the potential to lead to areas of deficiency in nursing without correction or oversight at the facility. Cross Reference F727 Findings: During a concurrent interview and record review on 12/20/2024 at 4:30 PM with the Administrator (ADM), the Quality Assurance Performance Improvement (QAPI) Meeting attendance records dated 9/20/2024 and 10/24/2024 were reviewed. The attendance records did not indicate a DON attended the meeting. The ADM stated there was no DON on the attendance record because the facility did not have a DON employed. The ADM stated having a DON employed was important because the DON over-saw nursing services which is the direct care given to the patients. During a review of the facility's policy and procedure (P&P) titled, Quality Assurance and Performance Improvement [QAPI] Program - Governance and Leadership, revised 3/2020, indicated, 6. The following individuals serve on the committee: b. Director of Nursing Services.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 48729 Based on observation, interview and record review, the facility failed to ensure 15 out of 19 resident rooms (Rooms 3, 4, 5, 6, 7, 8, 9, 10, 12, 14, 16, 20, 21, 22, 23) met the minimum requirement of 80 square feet (sq. ft., unit of measure) per resident in rooms with more than one resident. Nine rooms had two residents per room and seven rooms had three beds per room. This deficient practice had the potential to result in not having enough space for nursing staff to provide resident hygiene care, or the ability of residents to reside in their room comfortably. Findings: During a review of the facility's Client Accommodation Analysis (CAA), dated 12/20/2024 the CAA indicated the following rooms were less than 80 sq. ft. per resident: Room: No. of Beds: Room Size: Floor Area: 3 2 11.5 ft. x 13.5 ft. 155.25 sq. ft. 4 2 11.5 ft. x 13.5 ft. 155.25 sq. ft. 5 2 11.5 ft. x 13.5 ft. 155.25 sq. ft. 6 2 11.5 ft. x 13.5 ft. 155.25 sq. ft. 7 3 13.5 ft. x 16 ft. 216 sq. ft. 8 3 13.5 ft. x 18 ft. 243 sq. ft. 9 2 11 ft. x 13.5 ft. 148.5 sq. ft. 10 3 13.5 ft. x 17 ft. 229.5 sq. ft. 12 3 12 ft. x 18.5 ft. 222 sq. ft. 14 3 12 ft. x 18.5 ft. 222 sq. ft. 16 3 12.5 ft. x 18.5 ft. 231.5 sq. ft. 20 2 10 ft. x 15 ft. 150 sq. ft. 21 2 10 ft. x 15 ft. 150 sq. ft. 22 2 10 ft. x 15 ft. 150 sq. ft. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	23 2 10 ft. x 15 ft. 150 sq. ft. During a review of the facility's room waiver request letter, dated 12/17/2024, the letter indicated there was adequate space for nursing care and the health and safety of residents occupying these rooms were not in jeopardy. The letter indicated the requested rooms were in accordance with the special needs of the residents and did not have any adverse effects on the resident's health and safety or impeded the ability of any resident in the rooms to attain their highest practicable well-being. During an observation and walk through of the facility on 12/20/2024 at 12:48 PM with Maintenance Director (MD). Rooms 3, 4, 5, 6, 7, 8, 9, 10, 12, 14, 16, 20, 21, 22, and 23 were uncluttered and residents moved freely in their rooms. There were no residents who expressed any concerns about the room sizes. During an interview on 12/20/2024 at 12:56 PM with Certified Nursing Assistant (CNA) 2, CNA 2 stated there was enough space in each resident's room and CNA 2 was able to move around freely and complete resident care duties such as helping the residents and changing the bed sheets.