STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106123	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viera Del Mar Health and Rehabilitation Center	2355 Vidina Drive Viera, FL 32940

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on interview and record review, the facility failed to provide care and services, according to professional standards of practice, to avoid complications of a known medical condition and prevent rehospitalization for 1 of 2 residents reviewed for hospitalization , out of a total sample of 43 residents, (#574). The facility's failure to promptly identify and treat a change in condition and failure to obtain and implement physician orders in a timely manner resulted in actual harm for resident #574. The resident suffered altered mental status and debilitating symptoms which necessitated transfer to an acute care hospital for evaluation and treatment. Findings: Review of the medical record revealed resident #574, a [AGE] year-old female, was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a brain disorder) and liver cirrhosis. The resident was discharged to the hospital on 6/20/24. Cirrhosis is scarring of the liver that results from injury or long-term disease. The scar tissue impacts the function of the liver and affects its ability to clean the blood (retrieved on 8/05/24 from www.medlineplus.gov/cirrhosis.html). Hepatic encephalopathy develops when toxins or poisons such as ammonia, build up in the brain because the liver cannot break them down. It can cause nausea, vomiting, confusion, loss of consciousness, and coma (retrieved on 8/05/24 from www.medlineplus.gov/lab-tests/ammonia-levels). The General Admission Data assessment dated [DATE] revealed resident #574 was alert, easily arousable, cooperative, and oriented to person, place, time, and situation. The document indicated the admission nurse(s) contacted the resident's medical provider to reconcile her medications, and all orders were confirmed and verified. Review of the Order Summary Report revealed resident #574 had physician orders dated 6/09/24 for Lactulose 10 grams/15 milliliter (gm/ml), give 30 ml four times daily for hyperammonia, and Rifaximin 550 milligrams (mg), give one tablet every 12 hours for hyperammonia. (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Lactulose causes a decrease in blood ammonia concentration and reduces the degree of encephalopathy by drawing ammonia from the blood into the colon where it is excreted in an increased number of bowel movements (retrieved on 8/05/24 from www.liverfoundation.org/liver-diseases/complications-of-liver-disease/hepatic-encephalopathy/treating-hepatic-encephalopathy). Rifaximin 550 mg is an antibiotic medication that is usually administered twice daily. If you are taking Rifaximin to prevent hepatic encephalopathy, do not stop taking it without talking to your doctor as you may experience symptoms of encephalopathy (retrieved on 8/05/24 from www.medlineplus.gov/druginfo/meds/a604027.html). Review of resident #574's medical record revealed she had a care plan for antibiotic therapy related to liver disease, initiated on 6/11/24. The goal was the resident would receive the drug. The interventions instructed nurses to administer antibiotic medication as ordered, obtain pertinent labs and report to the physician. Review of a care plan for risk for alteration in neurological status related to a diagnosis of encephalopathy, initiated on 6/11/24, had a goal that resident #574 would be free from signs and symptoms of complications of neurological deficit and would maintain optimal status and quality of life. The interventions instructed nurses to administer medications as ordered and report signs and symptoms of neurological complications such as constipation, difficulty swallowing, decline in range of motion, decline in cognitive function, change in level of consciousness, and slurred speech. A care plan for liver disease related to cirrhosis, initiated on 6/17/24, had a goal that the resident would be free from signs and symptoms of liver complications including cognitive decline or mental status changes. The interventions included administer medications as ordered by the physician. The document indicated nursing staff would monitor, document, and report malaise, fatigue, constipation, altered level of consciousness, confusion, or disorientation, and notify the physician as indicated. The care plan read, Obtain and monitor lab/diagnostic work as ordered by [physician]. Report results and follow up as indicated. Review of a Psychiatry Evaluation Note dated 6/10/24 revealed resident #574 was newly admitted to the facility and was alert and oriented with appropriate affect and mood. The psychiatrist noted the resident had an organized thought process, intact thought associations, good insight and judgement, and was at her baseline status. A Physician/Practitioner Note dated 6/11/24 revealed Advanced Practice Registered Nurse (APRN) G reviewed resident #574's medical chart which included hospital records. APRN G noted the resident had a past medical history of nonalcoholic cirrhosis. His assessment findings showed the resident was alert, awake, able to follow simple commands, and able to communicate. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) Admission assessment with assessment reference date of 6/12/24 revealed resident #574 was admitted from a short-term general hospital. The document indicated she had adequate hearing and vision, clear speech, clear comprehension, and was able to express her ideas and wants. The resident's Brief Interview for Mental Status score was 15/15 which showed she was cognitively intact. The document revealed resident #574 did not exhibit inattention, disorganized thinking, or an altered level of consciousness. The MDS assessment indicated she displayed no behavioral symptoms and did not reject evaluation or care that was necessary to achieve her goals for health and well-being. Resident #574 participated in and provided information for the assessment, and her overall goal was to discharge to the community. Review of the medical record revealed a Late Entry Physician/Practitioner Progress Note dated 6/13/24 at 4:56 PM. The document was created four days later, on 6/17/24 at 4:56 PM, by APRN G who noted resident #574 denied any specific problems and remained alert and able to follow simple commands. The assessment showed the resident was comfortable, alert and oriented, and able to communicate. However, an Occupational Therapy Treatment Encounter Note dated 6/13/24 revealed resident #574 refused to get out of bed for her therapy session and complained of nausea. The therapy note read, Provided patient with bucket and reported to nursing. A Physical Therapy Treatment Encounter Note dated 6/13/24 indicated the resident refused to get out of bed for therapy. There were no associated nursing or provider progress notes regarding the resident's complaint of nausea or refusal to get out of bed on 6/13/24. Review of another Late Entry Physician/Practitioner Progress Note dated 6/15/24 at 2:00 PM, revealed APRN G wrote resident #574 denied any specific problems and remained alert and able to follow simple commands. The assessment showed the resident was comfortable, alert and oriented, and able to communicate. The note read, Nursing reports patient at baseline with no recent acute events.reviewed patient plan of care with assigned nurse, Nurse added no new patient concerns.Nursing to notify provider of any change in mentation or behavior. The document indicated resident #574's ammonia level was being monitored and the resident continued to receive Rifaximin 550 mg and Lactulose 45 ml. The ordered dosage of Lactulose on 6/15/24 was 30 ml and it was not increased to 45 ml until 6/17/24; therefore, the note did not accurately reflect the resident's active plan of care. A Laboratory progress note dated 6/16/24 at 2:52 AM, revealed Licensed Practical Nurse (LPN) B notified APRN G of resident #574's lab result. Review of the lab report showed the resident's ammonia level was elevated to 97 micromoles/Liter (mcmol/L). However, review of the Order Summary Report revealed no physician order for the stat or immediate lab, and review of nursing progress notes and APRN G's progress note on 6/15/24 showed no evidence of identification of a change in status or signs and symptoms of hyperammonia that required an urgent lab test. The medical record did not show a response from APRN G or any new orders to treat the resident's elevated ammonia level. According to the Merck Manual Professional Version (reviewed/revised December 2021), a normal Ammonia level is 23-47 mcmol/L (retrieved on 8/05/24 from www.merckmanuals.com/professional/resources/normal-laboratory-values/blood-tests-normal-values). Review of a Psychiatry Subsequent note dated 6/17/24 revealed the provider assessed resident #574 and noted, Mood is unwell. She reports nausea which is affecting her appetite. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A Physical Therapy Treatment Encounter Note dated 6/17/24 revealed resident #574 refused four separate attempts to participate in therapy sessions. An Occupational Therapy Treatment Encounter Note dated 6/17/24 read, .patient reporting not feeling well and too tired to get out of bed. Review of a Progress note dated 6/17/24 at 7:30 PM, revealed resident #574's family members voiced concerns that their mother had a history of high ammonia levels, complained of constipation with no bowel movement for at least two days, and was exhibiting increased confusion. LPN E notified the provider and received orders for an abdominal x-ray and a routine ammonia lab test. The provider increased the resident's Lactulose from 30 ml to 45 ml, almost 18 hours after the facility received and reported the stat ammonia lab result of 97 mcmol/L to APRN G. An Occupational Therapy Treatment Encounter Note dated 6/18/24 revealed resident #574, demonstrated increased fatigue on this day. A Progress Note dated 6/18/24 at 2:33 PM, revealed resident #574's son repeated his concerns about his mother. The document indicated he notified the Casabella UM that she, .did not have a [bowel movement] in 3 days and that his mother's ammonia level was high. Son wanted mother transfer to [Emergency Department]. The note revealed the UM informed the son his mother's needs could be met in the facility. She contacted the provider and obtained orders for another type of laxative drug and a stat ammonia lab test. Review of a Progress Note dated 6/18/24 at 7:01 PM, revealed resident #574 was alert with confusion, complained of continued constipation despite a small, hard bowel movement. The progress note indicated the resident's ammonia level had decreased. Review of the laboratory result dated 6/18/24 revealed the resident's ammonia level was 66 mcmol/L, still above the normal range. A Physical Therapy Treatment Encounter Note dated 6/19/24 revealed resident #574 remained in bed and, . had poor responsiveness to therapist throughout session and nursing was notified. Review of an Occupational Therapy Treatment Encounter Note dated 6/19/24 revealed resident #574 was, .lethargic this date and difficulty with arousal, nursing aware of [patient] status. Review of the medical record revealed the Casabella UM completed a Change in Condition note on 6/20/24 at 2:40 PM. The document indicated resident #574 had altered mental status and the provider recommended sending her to the hospital. There was no associated nursing progress note with details of the resident's status. A Late Entry Physician/Practitioner Progress Note dated 6/20/24 at 3:33 PM was created by APRN G on 6/21/24 at 3:33 PM. The document indicated he assessed resident #574 in her room, and as in all previous notes, described her as alert, awake, able to communicate and follow simple commands. APRN G noted the resident's ammonia level and mentation were improved, but her son was insistent that his mother required hospitalization . A progress note dated 6/20/24 at 3:50 PM, revealed resident #574 was transferred to the hospital by ambulance personnel, accompanied by a family member. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In a telephone interview on 8/05/24 at 7:07 PM, resident #574's daughter stated she received a text message from her mother on Monday 6/17/24 at 11:32 AM, that indicated she had abdominal pain, could not eat anything for breakfast, and had not had a bowel movement for a week. The daughter recalled her response to her mother was that the facility needed to check her ammonia level as it was probably increasing. She stated her mother stopped texting and she became worried, so she visited later that evening. The resident's daughter said, Her lunch was untouched, and the dinner tray was there as well. Her eyes were closed, and I touched her to wake her up. She did not seem like her normal self. She was not alert and not talking. Usually, she is excited to see me and asks about my kids. The daughter stated she expressed her concerns to the assigned night shift nurse who contacted APRN G and received orders for an abdominal x-ray and bloodwork. The daughter stated the nurse explained the results would likely not be available until the following morning, so she asked her to contact the physician again regarding sending her mother to the hospital. The resident's daughter stated the nurse returned and informed her she got push-back from the practitioner, who felt there was nothing the hospital could do that could not be done in the facility. The daughter recalled the following morning, on Tuesday 6/18/24, she returned to the facility at about 9:40 AM and her mother's uneaten breakfast was on the tray table. She stated there were two medication cups on the table beside the meal tray, one with pills and the other with 10 ml of liquid medication that appeared to be Lactulose, and no nurse in the room or nearby. The resident's daughter recalled the Casabella Unit Manager (UM) reassured her she would fix the situation, and she returned with an additional 30 ml cup of Lactulose. Resident #574's daughter stated no family members visited the facility on Wednesday 6/19/24, and by Thursday 6/20/24, her mother's condition had declined even more. On 8/01/24 at 2:29 PM, in a telephone interview with resident #574's son, he explained after about a week in the facility, his mother began exhibiting symptoms of high ammonia levels and she was barely responsive during the final three days. He stated the change in his mother's condition was significant as she was usually very alert, oriented, and talkative. The son recalled the facility denied several requests made by him and his sister to send his mother to the hospital as they noticed her symptoms worsening. He explained on Thursday, 6/20/24 at about 2:00 PM, he unexpectedly received a phone call from his mother's phone. He stated he was happy when he saw her number, as a call from her would suggest she felt better and was finally able to converse with him. Resident #574's son said, I was surprised because it was a [Certified Nursing Assistant] on my mom's phone, and she said my mom was not really responding so she thought it would help to hear my voice. I told her to get a nurse immediately. The son stated he waited for 25 minutes but did not hear back from a nurse, so he called the Casabella UM on her direct line and demanded she send his mother to the hospital. The resident's son emphasized that his mother's ammonia levels would not have escalated to that extent if she had been receiving her medication as prescribed. He stated he felt a significant factor was staff did not want to give the Lactulose at times because it caused frequent and/or loose bowel movements which they did not want to clean up. The resident's son explained as his mother became less responsive, it would have been difficult or almost impossible for her to take her medication orally, so he was not sure the medical record accurately reflected medications given. He explained when he arrived at the facility at approximately 3:30 PM, Emergency Medical Services (EMS) personnel were there, and his mother was unresponsive except for occasional slight moans. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of a written statement by resident #574's son dated 8/05/24 revealed when he arrived at the hospital his mother was unresponsive, and the Emergency Department (ED) nurse informed him the facility reported to EMS that was her baseline status. The son indicated he immediately called the Casabella UM and while on speakerphone, he asked her who informed EMS that his mother's current condition was her baseline. The document revealed the Casabella UM replied, Well she's been like that for a few days. Resident #574's son noted that the facility's delay in care did not make his mother's unresponsive state a new baseline. The statement indicated resident #574 was unable to swallow any medication and she required two courses of rectally administered Lactulose before her mental status improved. Review of resident #574's hospital record revealed an Emergency Department Clinical Report dated 6/20/24. The document indicated on arrival at the ED, EMS personnel gave the history of the resident's illness as decreased responsiveness for about a week. The physician assessment revealed resident #574 responded only to painful stimulus and bloodwork collected in the ED revealed her ammonia level was 141 mcmol/L. The hospital record showed the resident required Lactulose enemas to treat her elevated ammonia level that was, .likely secondary to her not receiving her Lactulose. The ED Primary Assessment Document showed the resident's Glasgow Coma Scale score on arrival was 7 based on best motor response as withdrawal from pain, best verbal response as incomprehensible words, and no eye opening. The Glasgow Coma Scale (GCS) is used to measure a patient's level of consciousness by assessing eye, motor, and verbal responses. A GCS score of 8 or less indicates the possibility of a severe traumatic brain injury (retrieved on 8/07/24 from www.webmd.com/brain/what-is-the-glasgow-coma-scale). On 8/01/24 at 5:37 PM, in a telephone interview with a Pharmacy Customer Service Technician, she validated pharmacy records showed only six tablets Rifaximin 550 mg were dispensed for the resident, which was enough to last for three days. She stated the pharmacy sent an authorization form to the facility, according to the protocol for any high-cost medication, but it was never returned. The Pharmacy Customer Service Technician verified no additional Rifaximin 550 mg tablets were dispensed for resident #574. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 8/01/24 at 2:43 PM, APRN G was informed the facility's pharmacy Packing Slip Details showed the pharmacy dispensed only a 3-day supply of Rifaximin 550 mg for resident #574. After review of the Medication Administration Record (MAR), he was told the resident did not receive three doses of Lactulose between 6/17/24 and 6/19/24, and despite documentation to the contrary, the resident's lethargy and nausea during that period made it highly unlikely that she received all doses of Lactulose as ordered. APRN G stated he was never made aware the resident's Rifaximin was not available, and nurses did not mention the drug required authorization due to the cost. APRN G verified medications should be administered as ordered, and if that was not possible, nurses should have contacted him. He said, My expectation is I will be notified about all refusals or medications not available. I could have made an adjustment, probably increased Lactulose since that was already shown to be effective. When asked about the delayed response to the stat Ammonia lab result of 97 mcmol/L reported on 6/16/24, APRN G acknowledged he received the result from LPN B via text message. He reviewed his communication records and confirmed there was no evidence he responded to the message. When informed the order to increase resident #574's Lactulose from 30 ml to 45 ml to treat her elevated ammonia level was not received until after 7:00 PM on 6/17/24, APRN G said, Eighteen hours is too long to respond to a lab. In a follow up telephone interview with APRN G on 8/02/24 at 1:22 PM, he stated he reviewed his communication records again and discovered he was notified of resident #574's refusal to take her medication only once, on 6/18/24. APRN G added that he had no recollection or documentation of ordering the initial stat ammonia lab on 6/15/24. On 8/01/24 at 3:08 PM, Certified Nursing Assistant (CNA) D joined the interview with APRN G and confirmed she spoke to resident #574's son on the phone on the afternoon of 6/20/24, the resident's last day in the facility. CNA D recalled from the beginning of the day shift, the resident's eyes remained closed, even when she informed her that breakfast was there. She stated it almost seemed as if resident #574 was ignoring her, and she reported to the nurse that the resident seemed different. CNA D explained during change of shift report that morning, the off going night shift CNA told her resident #574 had not responded to her during the night shift either. CNA D said, She was conscious but not responding. Even therapy had that same concern. APRN G confirmed he was not notified of the significant decrease in resident #574's level of consciousness. He validated CNA D's description of resident #574 depicted classic symptoms of a high ammonia level. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 8/01/24 at 1:23 PM and 8/05/24 at 4:52 PM, in telephone interviews, LPN B stated she assumed care of resident #574 on the night shift of 6/15/24, after she received change of shift report from LPN A. She explained LPN A never mentioned any concerns regarding the resident's clinical status, so she was surprised when another night shift nurse approached her with a note from LPN A that indicated resident #574 required a stat ammonia lab test. LPN B explained she called LPN A, who told her that as she left the facility, she ran into APRN G in the parking lot, and he gave her that order. LPN A wrote it on a piece of paper, handed it to another nurse who was on her way into the building, and told her to give it to LPN B. LPN B expressed disbelief and said, Really! We're doing things like this now? She stated she arranged for the stat lab after she texted APRN G and received confirmation he needed the test to be done. LPN B verified she did not receive a response from APRN G after she texted him the lab result and she texted him again on 6/16/24 at 6:37 AM, regarding contacting the day shift nurse if he had any new orders for the resident. LPN B stated LPN A returned the next morning for the day shift and she relayed the lab result to her. When asked about her notes on the electronic MAR dated 6/14/24 and 6/15/24 regarding the resident's Rifaximin that was not available, LPN B stated she wrote the notes after she thoroughly searched the medication room and the medication cart and realized it was not there. LPN B said, When I gave report to [LPN A] the next morning, I mentioned that the medicine was not there, and she was like a deer in the headlights.I told [LPN A] that when [APRN G] calls they need to get an alternative. I told her it's funny that some people are saying they give it, but it isn't here. LPN B expressed frustration that some nurses habitually documented they administered medications that were not given and said, No wonder her numbers are going high. On 8/02/24 at 12:26 PM, the Casabella UM described resident #574's baseline mentation as alert, oriented and chatty. The UM stated she was never made aware the resident's Rifaximin was not dispensed by the pharmacy beyond the initial 3-day supply. She acknowledged the resident's daughter informed her that her mother's ammonia level was high, she was not doing well, and she probably did not receive the correct dose of Lactulose. The UM verified resident #574's stat ammonia lab result on 6/16/24 was not addressed timely, and her expectation was nurses would have contacted her or the Director of Nursing if APRN G did not respond. The UM validated on 6/20/24, resident #574's son called her as he became concerned after his conversation with CNA D. The UM said, I went to check on her and she was drowsy, slurring, not sitting. I was concerned. I called [APRN G] on the phone and he said go ahead and send her out. The UM stated she could not explain why nurses' documentation did not show the decline in the resident's condition reported by CNAs and therapy staff, and she was unsure if medications were given as ordered. In an undated, written Case Study document, the facility's co-Medical Director wrote, It is critical for patients to adhere to their prescribed medication regimen. The Case Study validated the consistent failure to administer essential medications like Lactulose posed a significant risk to patients' health. The co-Medical Director noted the importance of adherence to both Rifaximin and Lactulose as a comprehensive treatment plan for liver disease. Review of the facility's policy and procedure Change in Resident Condition or Status - Resident Rights revised in June 2023, revealed the facility would notify the resident, the attending physician, and his/her representative of changes in the resident's medical or mental condition that included significant changes and the need to alter treatment. The document indicated a significant change of condition included a major decline that would not resolve itself without intervention, impacted more than one area of the resident's health status, and required interdisciplinary review and/or revision of the care plan. The policy read, The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the Facility Assessment, dated 3/22/24, revealed the facility would accept residents with common diseases and conditions that included digestive system disorders such as cirrhosis. The document indicated the facility would offer care and services to manage medical conditions by providing assessment, early identification of problems/deterioration, and management of medical symptoms. The Facility Assessment revealed nurses would administer medications needed by residents.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on interview and record review, the facility failed to provide pharmaceutical services, consistent with professional standards of practice, to ensure proper acquisition and administration of routine medication; and failed to appropriately dispose of discontinued medication to promote medication safety, for 1 of 2 residents reviewed for hospitalization , out of a total sample of 43 residents, (#547). Findings: Review of the medical record revealed resident #574, a [AGE] year-old female, was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a brain disorder) and liver cirrhosis. The resident was discharged to the hospital on 6/20/24. According to the American College of Gastroenterology, Cirrhosis of the liver refers to scarring of the liver which results in abnormal liver function. One of the symptoms associated with cirrhosis is hepatic encephalopathy caused by decreased filtration of toxins from the blood. The resulting buildup of poisons such as ammonia in the brain can lead to confusion, excess drowsiness, slurred speech, and coma. Medications prescribed to treat hepatic encephalopathy include Lactulose and/or certain types of oral antibiotics (retrieved on 8/08/24 from www.gi.org/topics/liver-cirrhosis/). Review of the Order Summary Report revealed resident #574 had physician orders dated 6/09/24 for Lactulose 10 grams/15 milliliter (gm/ml), give 30 ml four times daily for hyperammonia, and Rifaximin 550 milligrams (mg), give one tablet every 12 hours for hyperammonia. Review of resident #574's medical record revealed she had a care plan for antibiotic therapy related to liver disease, initiated on 6/11/24. The goal included the resident would receive the antibiotic (Rifaximin) as ordered. The interventions instructed nurses to administer antibiotic medications as ordered by the physician. Review of resident #574's Medication Administration Record (MAR) for June 2024 revealed Rifaximin 500 mg was scheduled for administration at 9:00 AM and 9:00 PM every day. The medication start date was noted as 6/10/24 at 9:00 AM. The MAR showed the drug was administered as ordered except for doses on 9:00 PM on 6/14/24, 6/15/24, 6/16/24; 9:00 AM on 6/17/24; and 9:00 PM on 6/18/24. Review of electronic Medication Administration Record (eMAR) notes revealed the following: On 6/14/24 at 10:25 PM, Licensed Practical Nurse (LPN) B did not administer resident #574's scheduled dose of Rifaximin 550 mg. She noted the medication was on order. On 6/15/24 at 10:25 PM, resident #574's Rifaximin was still not available. LPN B wrote that the drug remained on order, and the facility received a high-cost medication notice from the pharmacy. On 6/16/24 at 8:16 PM, LPN F noted resident #574's Rifaximin was still on order. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/17/24 at 8:23 AM, LPN E indicated she did not administer resident #574's Rifaximin. The note read, Medication on order, awaiting pharmacy arrival. On 6/18/24 at 10:15 PM, LPN H noted resident #574 refused all her scheduled medications, including Rifaximin 550 mg. On 8/01/24 at 1:23 PM and 8/05/24 at 4:52 PM, in telephone interviews, LPN B verified she was unable to administer resident #574's Rifaximin 550 mg doses on 6/14/24 and 6/15/24 as the medication was not available in the facility. LPN B confirmed she thoroughly searched the medication cart and the medication room and did not find it. She stated on the morning of 6/16/24 she reported off to LPN A at the end of her shift and informed her she needed to contact the prescriber to request an alternative drug. LPN B recalled LPN A appeared surprised when she told her it was strange that some nurses documented they gave a medication the facility did not have. On 8/01/24 at 5:37 PM, in a telephone interview with a Pharmacy Customer Service Technician, she validated pharmacy records showed a total of six tablets of Rifaximin 550 mg were dispensed for the resident, which was enough to last for three days. The Pharmacy Customer Service Technician explained the drug was categorized as a high-cost medication that required special authorization because a 14-day supply cost $1499.00. She stated the pharmacy sent an authorization form to the facility, but it had not been returned, so no additional Rifaximin 550 mg tablets were dispensed for resident #574. On 8/01/24 at 5:42 PM, in a telephone interview, a facility Pharmacist confirmed the pharmacy dispensed six Rifaximin tablets, a 3-day supply, to ensure the resident's immediate admission medication needs were met. He explained Rifaximin was an expensive drug that required authorization prior to routine dispensing and refilling. The Pharmacist stated the process was the pharmacy would send an authorization form, and the Director of Nursing would sign and return it. He reviewed the pharmacy records and stated the authorization request was sent multiple times in attempts to avoid a delay in sending resident #574's medication. An email from the facility's pharmacy, dated 8/01/24 at 9:12 PM, provided confirmation that on 6/10/24, the pharmacy sent a 3-day supply of Rifaximin 550 mg for resident #574, according to protocol for the first dispensing of a high-cost drug. The document indicated on that date, a high-cost form was printed and put in the tote, faxed to the facility, and also sent electronically. The timeline revealed the pharmacy repeated the procedures to obtain authorization for the drug on 6/14/24, when the 3-day supply was used up, and again on 6/17/24. The pharmacy's final attempt to obtain authorization was on 6/19/24, when a representative called the facility but did not get a response. Review of the MAR revealed after the initial 3-day supply of Rifaximin was completed, six nurses, LPNs A, E, F, I, J, and K, signed the document over an 8-day period to validate they had administered the drug. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/02/24 at 9:58 AM, the Montecito Unit Manager (UM) stated the facility initiated an investigation within the last 24 hours, after State Survey Agency staff identified the concern related to the availability of resident #574's Rifaximin. The Montecito UM said, During our investigation, some of the nurses informed us that they were using the medication that was supposed to be sent back [to the pharmacy] that belonged to another resident. She explained the medication was discontinued on 6/03/24 for other resident. The Montecito UM validated nurses borrowing medication from other residents' supplies was just as concerning as nurses documenting they gave a medication that was never dispensed by the pharmacy. She explained the facility's clinical management team reviewed the facility's 24-hour report in daily meetings and concerns related to resident #574's missed doses of Rifaximin and unavailability of the drug were never identified or addressed by nurse management. On 8/02/24 at 11:12 AM, LPN A was informed the MAR showed she administered resident #547's Rifaximin 550 mg four times, although the drug was not available for the resident. She stated she administered the medication from another resident's card. LPN A explained the medication had been discontinued and the card was in the medication room in a bin designated for discontinued medications that were to be returned to the pharmacy. LPN A said, I took medication from the patient who did not need it anymore. I know I should not be borrowing. She explained she retrieved the card of Rifaximin from the medication room and returned it to the other resident's section of the medication cart. LPN A stated discontinued medications were usually returned to the pharmacy within 24 hours and she could not explain why the card of Rifaximin would have been in the bin in the medication room from 6/03/24 to 6/14/24. In addition, LPN A could not explain how other nurses would have known to retrieve Rifaximin for resident #547 from another resident's section of the medication cart. On 8/02/24 at 11:40 AM, the Assistant Director of Nursing stated during an audit of all medication carts last night, the facility discovered a card of Rifaximin 550 mg with 17 pills. She confirmed the drug had been discontinued approximately two months ago, and the card should have been removed from the cart promptly and returned to the pharmacy in a timely fashion to prevent errors. Review of the facility's policy and procedure for Medication Storage and Labeling, revised in January 2024, read, The facility stores all drugs and biologicals in a safe, secure, and orderly manner. The document revealed discontinued drugs should be returned to the dispensing pharmacy or destroyed. On 8/02/24 at 12:16 PM, in a telephone interview, LPN I stated resident #574's Rifaximin 550 mg was not available, .so to do a good [medication] pass I borrowed the medication. I don't remember on how many occasions. She acknowledged the accepted standard of practice was to note the medication was not administered and notify the physician and pharmacy. On 8/02/24 at 12:26 PM, the Casabella UM stated she was nurses never informed her of any concerns related to obtaining resident #574's Rifaximin from the pharmacy. She confirmed nurses should not be borrowing medications from other residents. The Casabella UM said, I cannot speak to what the nurses were doing. I am not sure if the [medication] was given. On 8/02/24 at 1:08 PM, LPN E stated she typically would not document that she gave a medication if she did not do so, and she definitely would not borrow medications from one resident for another. She was not able to explain how or if she administered resident #547's Rifaximin 550 mg on 6/13/24 at 9:00 AM, although it had not been dispensed by the pharmacy after the initial supply had run out. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy and procedure for Medication Administration, revised in January 2024, described medications would be ordered and administered safely and as prescribed. The document read, Medications ordered for a particular resident may not be administered to another resident.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 35199 Based on observation, interview and a palatability test, the facility failed to serve palatable food at the appropriate temperature to residents in two of five halls, (300 and 600), in the facility. Findings: On the Recertification survey from 7/29/24 to 8/01/24 several residents on the 300 and 600 halls complained about cold food to the surveyors: On 7/29/24 at 11:06 AM, resident #105 stated the food was often cold, especially the eggs. On 7/29/24 at 12:38 PM, resident #104 stated the meals were sometimes late, which could cause food to be cold. On 7/30/24 at 11:00 AM, resident #79 described he often had cold food during his meals. On 7/30/24 at 11:44 AM, resident #37 complained breakfast was consistently cold and said other residents complained about the cold food too. Per the meal times posted at each nurse's station, the dining room and contained in the admission packet, the first lunch tray was scheduled to be sent out of the kitchen at 11:45 AM to the first hall to be served. The 600 hall was the last hall in the facility to be served meal trays out of the five dining areas. The document indicated lunch trays would be delivered at 12:45 PM for those residents residing on the 600 hall. During observation of the steam table and tray service plating in the kitchen on 8/01/24 at 12:46 PM, the hot meal items on the lunch trays for the 600 hall were covered with a clear plastic cover, instead of an insulated dome lid as other previous trays had. The hot meal items posted for lunch per the menu handout provided to residents were listed as beef tacos, refried beans, and yellow rice. On 8/01/24 at 12:58 PM, lunch trays arrived to the 600 hall via a non-insulated, non-heated, metal cart. At 1:12 PM, the last tray was delivered from the 600 hall cart. A previously requested test tray from the same cart was then sampled by two surveyors. The plate was covered by a clear acrylic lid and revealed yellow rice, refried beans and two soft tacos with ground meat, lettuce and cheese. The ground meat in the soft taco and the refried beans were lukewarm and not palatable to the two surveyors. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In conversations with the Chef and Certified Dietary Manager (CDM) on 8/01/24 at 1:20 PM, and 1:28 PM, the Chef explained the steam table temperatures were taken 30 minutes before they plated the first meal at 11:15 AM. The Chef shared the documented temperature log for the day's lunch which showed the taco meat was 170 degrees Fahrenheit (F), and the refried beans were 168 degrees F before plating started. The Chef confirmed he was aware of several grievances about hot food being served cold at the facility. The CDM confirmed the food temperatures were measured 30 minutes before the first tray was even served and said the temperature of the hot food met food temperature standards at the time the temperatures were taken. The Chef then validated the facility was missing 25-30 insulated plate lids to cover the hot food delivered to the 600 hall, and confirmed the facility did not utilize a thermal food transport system with insulated transport carts to maintain the hot food temperatures throughout the facility meal service.