STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555066	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Care Center of Fillmore, LLC	118 B St Fillmore, CA 93015

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 50707 Based on observation, interview and record revie and facility policy and procedure, the facility failed to ensure Interdisciplinary Team (IDT- a group of healthcare professionals from various disciplines who collaborate to provide comprehensive, patient-centered care) assessed resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for 1 of 20 sampled residents (Resident 51). This failure can result with resident not taking the medication correctly. Findings: During a concurrent observation and interview on 3/6/25 at 2:45 p.m., in Resident 51's room, two vials of DuoNeb (a medication in a small plastic container that contains as a liquid that you breathe into the lungs with a nebulizer (special breathing machine) breathing treatments were observed in Resident 51's drawer. When resident was asked about the medication, Resident 51stated he administers the medication himself. During a concurrent observation and interview on 3/6/25 at 3:02 p.m. in Resident 51's room, Licensed Nurse (LN 1) confirmed the two DuoNeb vials in Resident 51's drawer and stated, they shouldn't be there, and that the resident was not allowed to administer the breathing treatments himself. During an interview with the Director of Nursing (DON) on 3/6/25 at 1:39 p.m., DON stated that an IDT meeting is required to determine whether a resident can safely self-administer medications, along with a physician order. DON acknowledged there was no IDT meeting for the authorization for Resident 51 to self-administer medications. During a review of the facility's policy and procedure (P&P) titled Self- Administration of Medications, revised February 2021, the P&P indicated, 1. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident.

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

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

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 40560 Based on observation interview and record review, the facility failed to have the most current survey results accessible to the public, in the facility survey results binder. This facility failure denied the opportunity for residents, family members, and legal representatives of residents, to be aware of the most recent survey results. Findings: During a concurrent observation and interview, on 3/6/25 at with the Director of Nursing (DON) inside the facility's main entrance, the facility's survey results binder was reviewed. The most current survey results in the binder were from 5/22/24. The survey results binder lacked the survey results from 8/8/24 through 2/19/25. The DON acknowledged the survey results binder was not current and verbalized the survey results binder would need to be updated. During a review of the facility's policy and procedure tilted Survey Results, Examination of dated 4/7, indicated in part A copy of the most recent standard survey, including any subsequent extended surveys, follow-up revisits reports, etc., along with state approved plans of correction of noted deficiencies, is maintained in a 3-ring binder located in an area frequented by most residents, such as the main lobby or resident activity room, hallway.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 44589 Based on observation, interview and record review, the facility failed to accurately assess 2 of 20 sampled residents (Resident 35 and 39) using the Minimum Data Set (MDS - a standardized tool used to assess and plan care of residents in a nursing home) when: 1. Resident 35 - had an inaccurate language assessment. 2. Resident 39 - had an inaccurate functional status assessment. These failures resulted in the facility reporting inaccurate data to Centers for Medicare & Medicaid Services (CMS) that does not reflect Resident 35 and 39 statuses in MDS assessment. Findings: 1. During a review of Resident 35's Admission Record (AR), dated 3/6/25, the AR indicated, Resident 35's primary language is Spanish. During a review of Resident 35's most recent MDS Annual Assessment, Assessment Reference Date (ARD - the end of observation period), dated 12/21/24, section A for language indicated, Resident 35's preferred language is Spanish. Further review of the language assessment, section A1110B was coded 0 (meaning an interpreter was not needed to communicate with a doctor or health care staff). During an observation and interview on 3/5/25, at 10:59 a.m. with Resident 35, Resident 35 was observed responding in Spanish after being questioned in English translated by a Spanish speaking Certified Nursing Assistant (CNA 2) related to Resident 35's need for a Spanish speaking interpreter. Resident 35 verbalized, wanting to have an interpreter to discuss about his plan of care. Resident 35 further verbalized, that no one had offered and asked him this question before. During a concurrent record review and interview on 3/6/25, at 8:22 a.m. with the MDS Coordinator (MDSC), Resident 35's MDS Annual Assessment for language was reviewed. MDSC acknowledged, Resident 35 requiring a Spanish speaking interpreter. MDSC further acknowledged, the inaccurate assessment. During an interview on 3/7/25, at 10:41 a.m. with the Director of Nursing (DON), the DON acknowledged, the inaccurate MDS language assessment. 2. During a review of the P&P titled, Resident Assessment Instrument (RAI), dated October 2024, the P&P indicated, During each assessment period, the IDT [Interdisciplinary Team] will gather data to complete all sections of the MDS . Each person completing a section of the MDS attests to its accuracy by affixing his/her electronic signature to that section of the MDS .GG115 Functional Limitation in Range of Motion (ROM - describes how far and in what directions your joints can move). Code for limitations that interfered with daily functions or placed resident at risk of injury in the last 7 days. Coding 0 - no impairment, 1 impairment on one side . (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 35's AR, dated 3/6/25, the AR indicated, Resident 35 had a diagnosis of Multiple Sclerosis (a condition that affects the brain and spinal cord), foot drop on the foot (difficulty lifting the front part of the foot, causing to drag the toes during walking), difficulty in walking and muscle wasting and atrophy (thinning of muscle and loss of muscle tissue). During a review of Resident 39's MDS Significant Change (multiple areas of major decline or improvement on resident status) Functional Assessment, ARD 2/8/25, Resident 39's Functional Limitation on ROM was coded 0 (no impairment) on upper and lower extremities. During a review of Resident 39's Occupational Therapist (OT - healthcare professional that focuses on helping people participate in daily activities), dated 2/4/25, the OT assessment indicated, Resident 39 has an impairment on the left upper and lower extremities. During a concurrent record review and interview on 3/6/25, at 11:18 a.m. with the MDSC, Resident 39's MDS Significant Change Functional Assessment and OT assessment were reviewed. MDSC acknowledged, Resident 39's inaccurate functional assessment. During an interview on 3/7/25, at 10:41 a.m. with the DON, the DON acknowledged, Resident 39's inaccurate MDS functional assessment. A review of the facility's policy and procedure (P&P) titled, Resident Assessment Instrument (RAI), dated October 2024, the P&P indicated, During each assessment period, the IDT [Interdisciplinary Team] will gather data to complete all sections of the MDS . Each person completing a section of the MDS attests to its accuracy by affixing his/her electronic signature to that section of the MDS .Coding instruction for 110B . Code 1, Yes: if the resident .indicates there is no need or want of an interpreter to communicate with a doctor or healthcare staff. Ensure that preferred language is indicated.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44589 Based on observation, interview and record review, the facility failed to develop a comprehensive and individualized plan of care (care plan) for 3 of 20 Sampled residents (Resident 35, 11 and 47) when: 1. Resident 35's preference for communicating. 2. Resident 11's alarming devices on a wheelchair and bed. 3. Resident 47's need for the appropriate communication device based on physical condition . These failures had the potential for not meeting resident's needs. Findings: 1. During a review of Resident 35's most recent MDS Annual Assessment, Assessment Reference Date (ARD - the end of observation period), dated 12/21/24, section A for language indicated, Resident 35's preferred language is Spanish. Further review of the language assessment, section A1110B was coded 0 (meaning an interpreter was not needed to communicate with a doctor or health care staff). During an observation and interview on 3/5/25, at 10:59 a.m. with Resident 35, Resident 35 was observed responding in Spanish after being questioned in English translated by a Spanish speaking Certified Nursing Assistant (CNA 2) related to Resident 35's need for a Spanish speaking interpreter. Resident 35 verbalized, wanting to have an interpreter to discuss about his plan of care. Resident 35 further verbalized, that no one had offered and asked him this question before. During a concurrent record review and interview on 3/6/25, at 8:22 a.m. with the MDS Coordinator (MDSC), Resident 35's clinical record was reviewed. MDSC verified that Resident 35 speaks only Spanish and required a Spanish speaking interpreter when caring for Resident 35. MDSC further verified, the missing plan of care that addressed Resident 35's preferred language for communication. During an interview on 3/7/25, at 10:41 a.m. with the Director of Nursing (DON), the DON acknowledged, the missing care plan for communication for Resident 35. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised date 4/24/24, the P&P indicated, 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 50707 2. During a review of Resident 11's Admission Record (AR), dated 3/6/25, AR indicated Resident 11 was admitted on [DATE] with diagnoses that include dementia (a progressive state of decline in mental abilities) and repeated falls. (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 concurrent observation and interview on 3/4/25 at 12:40 p.m., with CNA 3, Resident 11 was observed in the activity room with a tab alarm (a safety device that sounds an alarm when a person tries to leave a bed, chair, or wheelchair) on his wheelchair. CNA 3 verbalized Resident 11 has three tab alarms, one on the wheelchair and two on the bed. During a concurrent interview and record review on 3/7/25 at 1:39 p.m., with the Director of Nursing (DON), Resident 11's care plans were reviewed. There is no documented evidence of a care plan to address the tab alarms. The DON stated, There is no care plan . there should be a care plan for alarms. During a review of the facility's policy and procedure (P&P) titled Falls and Fall Risk, Managing, revised 4/2024, the P&P indicated, Resident-Centered Approaches to Managing Falls and Fall Risk. 8. The use of alarms will be monitored for efficacy. During a review of the facility's P&P titled Care Plans, Comprehensive Person-Centered, revised date 4/24/24, the P&P indicated, 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 50657 3. During review of Resident 47's, Admission Record (AD) dated 3/5/25, the AD indicated a list of diagnoses including acute and chronic respiratory failure with hypoxia (difficulty breathing and not getting enough oxygen in the blood), gastrostomy (an opening into the stomach from the abdominal wall used to insert a tube to provide a route for liquid feeding), contracture of muscles (stiff muscles and bones), quadriplegia (partial or total loss of function in all four limbs and the torso) and tracheostomy (an incision on the front of the neck to open a direct airway to breathe). During an observation on 3/05/25 at 7:50 a.m. inside Resident 47's room, a push button call light was noted placed next to the resident on the bed however, not within the reach of the resident because Resident 47's was Quadriplegic and had a loss of functions to all four limbs. During a concurrent observation and interview on 3/07/25 at 9:11 a.m. with Certified Nursing Assistant (CNA 4), inside Resident 47's room, CNA 4 observed call light was laying over the bedside table. And CNA 4 explained that Resident 47 had just been bathed and CNA 4 forgot to put call light back within the resident's reach. CNA 4 stated the push button call light was not appropriate for the resident because Resident 47 is unable to push the button. During a concurrent observation and interview on 3/07/25 at 9:21 a.m. with the Director of Nursing (DON), inside Resident 47's room, the DON acknowledged the push button call light was inappropriate for Resident 47. DON stated, A more appropriate call light would be a pad alarm placed by his head. It is during the admission process that the appropriate type of call light is assessed, but in this case, it was not done. (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 the facility's policy and procedure titled, Answering the Call Light, dated September 2022, the P&P indicated Purpose: The purpose of this procedure is to ensure timely responses to the resident's requests and needs. General Guidelines: 1. Upon admission and periodically as needed, explain, and demonstrate use of the call light to the resident. 2. Ask the resident to return the demonstration .5. Ensure that the call light is accessible to the resident when in bed .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50707 Based on observation, interview, and record review, the facility failed to meet professional standards when : 1. Resident 719 supplemental oxygen was administered without a physician order. 2. Acetylcysteine (an oral inhalation used to help with breathing) was not administered as ordered by the physician for one of four sampled residents (Resident 27). 3. A respiratory therapist (RT1) failed to follow the facility's policy and procedure on medication administration (nebulizer /aerosol medication) and documentation for one of four sampled residents (Resident 27). 4. Resident 4's insulin (a medication to lower blood sugar levels) was not administered per physician's ordered insulin sliding scale parameters. 5. Resident 4's insulin medication was not administered in a timely manner. These failures can result to residents medications ordered at a specified dose for a designated reason with specific timing and maximum dosing parameters when needed to be missed. Findings: Review of [NAME] and [NAME], 7th Edition, Mosby's Fundamentals of Nursing, page 419 in the section titled, Legal Implications in Nursing Practice indicates, Nurses are obligated to follow physician order unless they believe they orders are in error or would harm clients. 1. During a review of Resident 719's Admission Record (AD), the AD indicated Resident 719 was admitted on [DATE] with diagnoses that include COVID-19 (contagious viral infection that affects breathing) and acute cough (a cough that begins suddenly and lasts for two to three weeks). During a concurrent observation and interview on 3/6/25 at 3:02 p.m. with Licensed Nurse (LN) 1, Resident 719 was observed in bed receiving supplemental oxygen through a nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen). LN 1 stated Yes, [Resident 719] uses oxygen. During a review of Resident 719's Minimum Data Set (MDS - a standardized tool used to assess and plan care of residents in a nursing home) dated 2/18/25, the MDS Section O- special treatments, procedures and programs indicated, Resident 719 received oxygen therapy on admission and while a resident in the facility. During a concurrent interview and record review on 3/6/25 at 3:50 p.m., with the Assistant Director of Nursing (ADON), Resident 719's Medication Review Report was reviewed. There is no physician order for the supplemental oxygen. ADON stated, I don't see an order and acknowledge there should be one. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled Oxygen Administration, revised October 2010, the P&P indicates Preparation 1. Verify that there is a physician order for this procedure. 2. During review of Resident 27's Admission Record (AR), the AR indicated Resident 27 was admitted on [DATE] with diagnoses that include acute and chronic respiratory failure with hypoxia (difficulty breathing and not getting enough oxygen in the blood), chronic obstructive pulmonary disease (progressive and irreversible damage to the airways and air sacs in the lungs causing breathing difficulties), and a tracheostomy (an incision on the front of the neck to open a direct airway to breathe). During an interview on 3/04/25 at 10:40 a.m. with Resident 27, Resident 27 stated the Acetylcysteine was not administered on the night of 3/03/25 and in the morning (3/04/25). Resident stated, I need that medication, I have breathing problems. During an interview on 3/04/25 at 3:29 p.m. with RT1, RT1 stated Resident 27 received the acetylcysteine twice on 3/03/25 during the 7 a.m. -7 p.m. shift but was unaware if the third treatment of acetylcysteine was given by the nocturnal shift. RT1 acknowledged not being able to administer the acetylcysteine the morning of 3/04/25 because there was no more acetylcysteine left. RT1 stated the medication refill was received on 3/04/25 in the afternoon. During a review of Resident 27's Medication Administration Record (MAR, a legal record of the drugs administered to a patient), dated March 1, 2025 - March 31, 2025, the MAR indicated, Resident 27 did not receive acetylcysteine on 3/04/25 at 09:00 a.m. as scheduled. Further review of the electronic MAR notes indicated, Acetylcysteine Inhalation Solution 20% .Waiting for meds from pharmacy. Pt. aware. There was no documented evidence indicating the physician had been notified of the missed acetylcysteine dose. During a review of the facility's policy and procedure (P&P) titled, Policy and Procedure in Medication Administration, dated January 2024, the P&P indicated in part, 1. Drugs must be administered in accordance with the written orders of the attending physician. 3. During a concurrent observation and interview on 3/05/25 at 4:06 p.m. with RT1, outside Resident 27's room, RT1 was observed holding a clear plastic cap with clear liquid. RT1 stated she was about to give Resident 27 the Acetylcysteine Inhalation Solution 20 % that had just been received from the pharmacy. After administering the inhalation medication, RT1 reviewed the MAR. The MAR indicated acetylcysteine was administered at 1300 and the next scheduled dose was at 5:00 p.m. RT1 stated the acetylcysteine was not given at 1300 because the resident prefers to have it done at 4:00 p.m. RT1 stated it was documented as given in the electronic medical record so the MAR doesn't flag in red. During a review of the facility's P&P titled, Policy and Procedure in Medication Administration, dated January 2024, the P&P indicated in part, 1. Drugs must be administered in accordance with the written orders of the attending physician .12. Medications must be immediately charted following the administration by the licensed nurse that administers the medication .13. All medications will be administered following the scheduled medication administration for medication for routine medications unless otherwise specified by MD which is different from the routine medication administration schedule. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During review of Resident 4's AD, the AD indicated Resident 4 was admitted on [DATE] with diagnoses that include gastrostomy (an opening into the stomach from the abdominal wall used to insert a tube to provide a route for tube feeding) and type 2 diabetes mellitus (chronic condition where the body does not use insulin properly or does not produce enough insulin to regulate blood sugar levels) with hyperglycemia (high blood sugar). During a review of Resident 4's MAR, dated 01/01/25 - 01/31/25 and 02/01/25 - 02/19/25, the MAR's indicated Insulin Aspart (a synthetic, rapid-acting insulin analog used to treat diabetes) Solution Cartridge 100 Unit/mL subcutaneously (under the skin) before meals and at bedtime related to Type 2 Diabetes Mellitus with Diabetic Neuropathy (a complication of diabetes that damages the nerves, affecting their ability to send and receive signals), unspecified. Inject as per sliding scale: If 150-200 = 6 units, 201-300 = 9 units, 301 - 400 = 12 units, >400 = 15 units and notify MD. Upon further review of Resident 4's MAR's, the MAR's indicated insulin was not given, and the reasons were coded as 5 (Hold/See Nurse Notes) on the following dates and times: 1/07/25 at 06:00 a.m., BS was 192 (6 units should have been administered per MD order) 1/19/25 at 11:00 a.m., BS was 155 (9 units should have been administered per MD order) 1/19/25 at 17:00 p.m., BS was 150 (6 units should have been administered per MD order) 1/29/25 at 06:00 a.m., BS was 217 (9 units should have been administered per MD order) 1/30/25 at 06:00 a.m., BS was 178 (6 units should have been administered per MD order) 1/31/25 at 06:00 a.m., BS was 189 (6 units should have been administered per MD order) 2/01/25 at 06:00 a.m., BS was 171 (6 units should have been administered per MD order) 2/05/25 at 06:00 a.m., BS was 177 (6 units should have been administered per MD order) 2/08/25 at 06:00 a.m., BS was 160 (6 units should have been administered per MD order) 2/12/25 at 06:00 a.m., BS was 191 (6 units should have been administered per MD order) 2/17/25 at 06:00 a.m., BS was 186 (6 units should have been administered per MD order) 2/25/25 at 06:00 a.m., BS was 151 (6 units should have been administered per MD order) 2/26/25 at 06:00 a.m., BS was 170 (6 units should have been administered per MD order) 2/28/25 at 06:00 a.m., BS was 163 (6 units should have been administered per MD order) During a review of Resident 4's Progress Notes (PN - a written record of a patient's health and treatment), dated 02/03/25 - 03/06/25, the PN indicated the Aspart insulin was held for episodes of low BS. There was no documented evidence indicating the physician had been notified of low episodes of BS. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/07/25 at 4:15 p.m. with the Assistant Director of Nursing (ADON), ADON acknowledged the insulin sliding scale was not followed for Resident 4 on multiple dates in January and February 2025. During a review of the facility's P&P titled Policy and Procedure in Medication Administration, dated January 2024, the P&P indicated, 8. Diabetic resident on insulin should follow MD order and comply with the sliding scale. M.D. should be notified if blood sugar is below 60 or over 400. FBS (fasting blood sugar) should be done before diabetic medication is administered. Hold diabetic medication if there is an NPO order unless M. D. has specific ordered. 5. During a review of Resident 4's MAR, dated 01/01/25 - 01/31/25 and 02/01/25 - 02/28/25, and the Location of Administration (LOA, a record with the name of the medication, scheduled time, administration time, route, and location of administration) indicated three insulin orders were administered greater than one hour before or after the scheduled time for the following: Insulin Aspart (a synthetic, rapid-acting insulin analog used to treat diabetes) Solution Cartridge 100 Unit/mL subcutaneously (under the skin) before meals and at bedtime related to Type 2 Diabetes Mellitus with Diabetic Neuropathy (a complication of diabetes that damages the nerves, affecting their ability to send and receive signals), unspecified. Inject as per sliding scale. 1/10/25 scheduled at 17:00 administered at 19:47 (1 hour and 45 minutes later) 1/25/25 scheduled at 11:00 administered at 14:15 (3 hours and 15 minutes later) 1/25ter/25 scheduled at 17:00 administered at 19:47 (2 hours and 45 minutes later) 1/27/25 scheduled at 11:00 administered at 12:41 (1 hour and 41 minutes later) 1/28/25 scheduled at 11:00 administered at 12:31 (1 hour and 31 minutes later) 1/29/25 scheduled at 17:00 administered at 18:50 (1 hour and 50 minutes later) 2/02/25 scheduled at 17:00 administered at 18:45 (1 hour and 45 minutes later) 2/03/25 scheduled at 17:00 administered at 18:18 (1 hour and 18 minutes later) 2/04/25 scheduled at 11:00 administered at 13:17 (2 hours and 17 minutes later) 2/07/25 scheduled at 17:00 administered at 19:25 (2 hours and 25 minutes later) 2/12/25 scheduled at 17:00 administered at 18:27 (1 hour and 27 minutes later) 2/13/25 scheduled at 17:00 administered at 18:49 (1 hour and 49 minutes later) 2/25/25 scheduled at 21:00 administered at 23:13 (2 hours and 13 minutes later) (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Lantus Subcutaneous Solution 100 UNIT/ML (Insulin Glargine) Inject 54 units subcutaneously two times a day related to type 2 diabetes mellitus with hyperglycemia [scheduled times are 0900 and 1700] and Lantus Subcutaneous Solution 100 UNIT/ML (Insulin Glargine) Inject 9 units [order date 11/20/24 - 1/22/25], 11 units [order date 1/22/25 - 2/17/25], and 13 units [order date 2/17/25] subcutaneously at bedtime related to type 2 diabetes mellitus with hyperglycemia [scheduled time listed as 2100]. 1/05/25 scheduled at 09:00 administered at 10:35 (1 hour and 35 minutes later) 1/07/25 scheduled at 09:00 administered at 10:30 (1 hour and 30 minutes later) 1/10/25 scheduled at 17:00 administered at 22:29 (5 hours and 29 minutes later) 1/10/25 scheduled at 21:00 administered at 22:33 (1 hour and 33 minutes later) 1/12/25 scheduled at 17:00 administered at 18:24 (1 hour and 24 minutes later) 1/17/25 scheduled at 17:00 administered at 18:50 (1 hour and 50 minutes later) 1/19/25 scheduled at 09:00 administered at 12:45 (3 hours and 45 minutes later) 1/23/25 scheduled at 09:00 administered at 10:56 (1 hour and 56 minutes later) 1/25/25 scheduled at 09:00 administered at 14:14 (5 hours and 14 minutes later) 1/25/25 scheduled at 17:00 administered at 19:46 (2 hours and 46 minutes later) 1/29/25 scheduled at 09:00 administered at 10:40 (1 hour and 40 minutes later) 1/29/25 scheduled at 17:00 administered at 18:51 (1 hour and 51 minutes later) 1/30/25 scheduled at 17:00 administered at 19:00 (2 hours later) 2/02/25 scheduled at 09:00 administered at 12:04 (3 hours and 4 minutes later) 2/02/25 scheduled at 17:00 administered at 18:44 (1 hour and 44 minutes later) 2/03/25 scheduled at 17:00 administered at 18:17 (1 hour and 17 minutes later) 2/05/25 scheduled at 09:00 administered at 11:15 (2 hours and 15 minutes later) 2/07/25 scheduled at 09:00 administered at 10:20 (1 hour and 20 minutes later) 2/07/25 scheduled at 17:00 administered at 19:25 (2 hours and 25 minutes later) 2/08/25 scheduled at 17:00 administered at 18:21 (1 hour and 21 minutes later) 2/09/25 scheduled at 17:00 administered at 18:20 (1 hour and 20 minutes later) (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/12/25 scheduled at 17:00 administered at 18:27 (1 hour and 27 minutes later) 2/13/25 scheduled at 17:00 administered at 18:48 (1 hour and 48 minutes later) 2/15/25 scheduled at 09:00 administered at 11:08 (2 hours and 8 minutes later) 2/18/25 scheduled at 17:00 administered at 18:46 (1 hour and 46 minutes later) 2/23/25 scheduled at 17:00 administered at 18:37 (1 hour and 37 minutes later) 2/25/25 scheduled at 21:00 administered at 23:14 (2 hours and 14 minutes later) 2/26/27 scheduled at 09:00 administered at 12:26 (3 hours and 26 minutes later) During an interview on 3/07/25 at 4:15 p.m. with the Assistant Director of Nursing (ADON), ADON acknowledged the insulin was not administered as scheduled for Resident 4 on multiple dates in January and February 2025. During a review of the facility's P&P titled, Policy and Procedure in Medication Administration, dated January 2024, the P&P indicated in part, 4. Medication must not be prepared in advance and must be administered within one hour before or after administration time per M.D. order.

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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** 13095 Based on inspection of the facility's Medication storage room on Unit 3, interview with the facility's IP, and review of the facility's policy and procedures the facility failed to: 1. follow their policy and procedure for sharps waste, 2. ensure that Emergency Drug supplies (E-Kits), had not been opened for more than 72 hours as outlined in the facility's policy and procedure, 3. ensure that no expired medications were available for use, 4. ensure that medications were administered in accordance with the hospital's policies and procedures and 5. ensure that medications are immediately documented in the Medication Administration record (MAR) after the administration of medications to a resident. Findings include: 1) Inspection of the facility's Blue and white (non-controlled) waste containers (which were open, and not closed or sealed), the surveyor found three syringes full of drugs with needles still attached to the syringes. One syringe contained the dilutant for Glucagon (1 ml) and the other two syringes contained (Enoxaparin 40mg/0.4 ml). Enoxaparin is a low molecular weight heparin (also known as an anticlotting drug). During an interview with the facility's Infection Prevention Nurse (IP) on 3/4/2025 at 10:35 am, the IP stated that the facility's P & P indicates that sharps (needle syringes) are not to be put into these containers (non-controlled waste bins), which were open and not locked. [NAME] indicated that the facility's policy and procedure labeled syringe and needle disposal, dated 1/2025 read: Policy, used syringes and needles are disposed of safely and in accordance with applicable state laws and safety regulations .Immediately after use, syringes and needles are placed into a puncture resistant, one-way containers specifically designed for that purpose .the disposal containers are fitted with a lid that prohibits reaching into the container. 2) Further inspection of the medication storage room on Unit 3 revealed an Antibiotic Emergency drug kit (E-Kit). This E-kit had been opened on 2/24/2025 at 5:00 pm when one of the facility's nursing staff had retrieved Metronidazole 500mg capsules for unsampled resident 65. This emergency drug kit had not been replaced since it had originally been opened on 2/24/2025. This E-Kit had not been replaced, as outlined in the facility's policy and procedure for 8 days, after opening. Review of the facility's policy and procedure entitled: Emergency Kit (E-Kit) Use, dated 1/2025, read: 6. The pharmacy is to be notified as soon as possible that the E-Kit has been opened so that it can be replaced within 72 hours (3 days). Additional inspection of the facility's Narcotic E-Kit on station 3, revealed that this E-Kit had been opened by facility staff for the removal of Alprazolam 0.25 mg tablets on 2/20/2025 at 1:00 am for one resident. The Narcotic E-Kit had been opened for 12 days, without being replaced, contrary to the facility's policy and procedure above. 3) Inspection of the Director of Nurse's medication storage room on 3/4/2025 at 2:55 pm, revealed one case of Ceftazidime 2-gram vials for reconstitution and injection (a total of 10 vials), with an expiration date of 7/2024 (almost 8 months beyond the drug manufacturer's expiration date). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) Interview with the medication Nurse on the facility's subacute station on 3/5/2025 and 3/6/2025 between 8:25 am and 11:00 am, revealed that these medication nurses (LVNs 1 & 3), indicated that all of the medication Nurses, on all of the Nursing units within the facility, have to start passing their medications to the residents, as early as 7:20 am and/or as late as 7:40 am (for medications which are due at 9:00 am according to the physician orders), in order for the nurses to finish their medication administration tasks in the morning, around 11:00 or 11:15 am. Concurrent interviews with Nursing staff on Stations 1, 3, and 4 confirmed that they all have to start passing medications every morning about 7:20 am. When these Nurses were asked why they had to start medication pass every day outside of the facility's policy and procedure which is entitled: Policy and procedure in Medication Administration, dated 1/2025, read: 4. Medication must and administered within one hour before or after administration time per M.D. order. The 1 hour before or 1 hour after policy and procedure means that the medication nurse could start passing their medications to the residents at 8:00 am and they must complete their medication pass by 10:00 am. The facility's policy and procedure above also read: 13. All medications will be administered following the scheduled medication administration for routine medication unless otherwise specified by M.D. which is different from the routine medication administration schedule. Review of the current physician's orders revealed that, no physician orders had been written which specified any different times for the administration of any medications. All of the Nurses indicated that it was impossible for them to pass all of the morning medications timely, for the following reasons: 1. each medication Nurse was also responsible for administering all of the treatments on their station, 2. these medication Nurses were also responsible for any admissions which came onto the unit, 3. medication Nurses were responsible for addressing any resident falls which occurred on their units, 4. Receiving and accepting any new medications and emergency drug kits which are being delivered to the facility, these are just a few examples why these Medication Nurses are unable to provide the morning medications to the residents. Further interview the Medication Nurses revealed that if the Medication Nurses had additional help with some of these tasks, that they may be able to get the residents their medications timely every day. 5) During an interview with Medication Nurse LVN 1, on 3/5/2025 at 11:15 am she acknowledged that she goes back after giving her medications in the morning and signs for these medications, after she finishes her medication passing the morning. She stated that: she does this in part because when she starts passing medications before 8:00 am and if she enters these medication administrations into the facility's computer then, these medications which had been given before 8:00 am, would get flagged by the computer for these administration entries. This practice is also contrary to the facility's policy and procedure entitled: Policy and procedure in Medication Administration, dated 1/2025, read: 12. Medications must be immediately charted following the administration by the license Nurse who administered the medication. This medication Nurse failed to follow this policy and procedure.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 13095 Based on Medication Pass observation, review of the resident's Medication Administration Record (MAR) and Physician's orders, Two out of two medication nurses observed for a total of 45 medication pass opportunities. Out of these 45 medication pass opportunities, there were a total of 8 medication errors which were observed. These 8 medication errors resulted in an overall medication error rate of 17.7% for the facility. Findings include: This LVN 3 administered medications to sample Resident 29 on 3/6/2025 at 9:00 am, which included Divalproex DR 250 mg tablet. The medication nurse proceeded to crush all of this resident's medications including this resident's Divalproex which had the designation of DR on the label of the bubble pack. Review of the manufacturer's package insert for this medication read: .The tablets should be swallowed whole and can be taken with or without food, Divalproex sodium delayed-release tablets are intended for oral administration. Divalproex sodium delayed-release tablets should be swallowed whole and should not be crushed or chewed, based on the drug manufacturer Aidarex Pharmaceuticals LLC.'s package insert. The DR on the product label stands for Delayed Release. By crushing this DR formulation, the Nurse altered the delivery of this making it immediate release rather than delayed release, which this product had been designed to be delivered. This resulted in one medication error. During a medication pass observation on 3/5/2025 at 8:27 am with LVN 1, this nurse passed medications to sampled Resident 63, this Medication Nurse administered 10 medications to this resident, with Cranberry juice and Ready Care (Med Pass). Upon review of Resident's Physician's orders and Resident 63's Medication Administration Record (MAR), the following 9:00 am medications had not been administered to this resident as ordered by the resident's physician: 1. Cetizine HCL 10 mg, 2. Magnesium Oxide 400 mg, 3. MiraLAX 3350 Powder, 4. Thera tears Ophthalmic Solution 1 drop in both eyes, and 5. Cranberry Oral tablet 450 mg. During an interview on 3/5/2025 at 11:15 am with the medication Nurse (LVN 1), this nurse acknowledged that her medication process is to give all of her medications to the residents first and then go back later to sign off all of the medications that she had previously given. The medication Nurse during the interview on 3/5/2025 at 11:15 am was asked if she had given this resident any other medications to this resident outside of the time that the surveyor had observed medication pass and the medication Nurse indicated that she had only given Resident 63 medications when the surveyor had been present for that morning. The medication Nurse had also been asked if she could recall giving any of the five medications above to resident 63 on the morning of 3/5/2025 and the nurse confirmed that she did not remember giving any of these medications to resident 63 that morning. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medication Nurse (LVN 1) had also been observed during the medication pass, administering medications to sampled Resident 27. The medication Nurse was observed administering Testosterone Gel 1.62 % to Resident 27. Two pumps of the Testosterone had been administered to Resident 27, yet during a review of the physician's order indicated that this resident should have only been administered 1 pump of Testosterone. Resident 27 also received Diclofenac Sodium cream (approximately 1 inch in total) [non-steroidal anti-inflammatory cream), which had been administered to both sides the resident's neck. Review of the Physician's order, written on 8/28/2024 read: .apply 2 inches to affected area. The medication Nurse only administered half of the dose of the Diclofenac to this resident. The culmination of these 8 medication errors resulted in this facility's medication error rate of 17.7%.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 13095 Based on review of the facility's medication refrigerator logs, review of the facility's policy and procedures, and interview with the facility's I P Nurse the facility failed to ensure that the refrigerator temperatures had been documented and remained within the temperature requirements as outlined by the facility's policy and procedure. Findings include: Inspection of the facility's Medication refrigerator temperature logs for station 3 on 3/4/2025 at 4:10 pm revealed that on 12/4/2024 the refrigerator temperature had been recorded as 35-degree Fahrenheit (which was below the facility's policy range). Review of the facility's policy and procedure entitled: Policy and Procedure on medication refrigerator temperature, date 1/2025, read: Per regulations, the Medication refrigerator temperature range should be between 36 degrees Fahrenheit and 46 degrees. Further review of the facility's refrigerator logs revealed that on 2/19/2025, that no temperature had been documented on the facility's refrigerator temperature logs, so the facility was unable to indicate what the actual temperature of the refrigerator was on that date.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43019 Based on observation, interview and record review, the facility failed to follow policies and procedures for labelling and dating foods. This failure has the potential for Foodborne illnesses (infections or intoxications caused by consuming contaminated food or beverages). Findings: During an observation on 03/05/25 at 9:00 AM, the following were observed: 6 large bins each containing rice, pinto beans, long grain rice, brown rice and split peas with different dates but does not indicate received date/opened date and or expiry date; 1 bin labelled pasta with dated 9/18/24 not indicating expiry date or open date and contains 2 packs of pasta with 2 different dates; 1 box containing mixed vegetables, baby lima beans, green beans but the labeled delivery dates on the side of the box is not specific for the packaged produce. During an interview on 03/05/25 at 07:30 AM with the Kitchen Manager (KM) and Dietician (DT), both staff acknowledge the labelling is not specific and should indicate the expiry date and or opened date. During a review of Policies and Procedures (P&P) titled Labelling and Dating of Foods dated 2023, the labelling and dating of foods indicated in part Newly opened food items will need to be closed and labelled with an open date and used by date that follows the various storage guidelines .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50657 Based on observation, interview, and record review the facility failed to maintain infection control practices when: 1. Respiratory care equipment was not stored properly after use by Residents (4 and 27) 2. Oxygen plastic tubing and nasal cannula were not labelled according to the facility's policy for one of four residents (Resident 27). 3. Personal protective equipment (PPE) was not available prior to entering resident rooms on contact precautions in rooms [ROOM NUMBERS]. These facility failures had the potential to result in cross-contamination (the transfer of harmful bacteria) that could impact residents' health and safety and cause preventable Healthcare Associated Infections (HAI) for residents with compromised condition. Findings: 1. During review of Resident 4's, Admission Record (AD), the AD indicated diagnoses including gastrostomy (an opening into the stomach from the abdominal wall used to insert a tube to provide a route for tube feeding), dysphagia (difficulty swallowing) following a cerebral infarction (blood flow to the brain is interrupted), type 2 diabetes mellitus (chronic condition where the body does not use insulin properly or does not produce enough insulin to regulate blood sugar levels) with hyperglycemia (high blood sugar) and neuropathy (numbness, weakness, and pain from nerve damage), hemiplegia (paralysis on one side of the body) affecting the right dominant side. During an observation on 3/04/25 at 10:02 a.m. in Resident 4's room, a nebulizer (a device that converts liquid medication into a fine mist, allowing it to be inhaled directly into the lungs) with attached nose mask and tubing were observed on top of a nightstand exposed and not covered. During an interview on 3/05/25 at 08:20 a.m. with respiratory therapist (RT), RT stated that oxygen masks and tubing must be stored inside a plastic bag with the resident's name when they are not in use. During an observation and interview on 3/05/25 at 8:50 a.m. with the assistant director of nursing (ADON), the ADON stated the facility's policy is to store nebulizer, ventilator, and oxygen equipment inside a plastic bag when not in use. The ADON acknowledged resident 4's nebulizer mask was not stored appropriately per facility policy. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During review of Resident 27's, Admission Record (AD) the AD. indicated diagnoses including acute and chronic respiratory failure with hypoxia (difficulty breathing and not getting enough oxygen in the blood), pseudomonas (bacteria that causes infections in people with weakened immune systems), chronic obstructive pulmonary disease (progressive and irreversible damage to the airways and air sacs in the lungs causing breathing difficulties), methicillin resistant staphylococcus aureus infection (bacterial infection that is resistant to many common antibiotics), and tracheostomy (an incision on the front of the neck to open a direct airway to breathe). During an observation on 3/04/25 at 10:40 a.m. in Resident 27's room, oxygen tubing was wrapped around a portable oxygen tank without a label or date, and it was not stored inside a plastic bag. During a concurrent observation and interview on 3/06/25 at 9:52 a.m. inside Resident 27's room, with Licensed Nurse (LN 4) LN 4 acknowledged there was no date or label on the oxygen nasal canula and oxygen tubing that was wrapped around oxygen tank located on Resident 27's wheelchair. LN 4 further stated the nasal cannula and tubing were not stored inside a plastic bag as required by the facility's policy. During a review of the facility's policy and procedure (P&P) titled Departmental (Respiratory Therapy) - Prevention of Infection, dated November 2011, the P &P indicated, Purpose: The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. Infection Control Considerations Related to Medication Nebulizers/Continuous Aerosol: 7. Store the circuit in plastic bag, marked with date and resident's name, between uses. Control Considerations Related to Oxygen Administration 7. Change the oxygen cannulae and tubing every seven (7) days, or as needed. 8. Keep the oxygen cannulae and tubing used PRN in a plastic bag when not in use. 3. During an observation on 3/05/25 at 08:32 a.m. in the sub-acute unit, contact precaution signs were posted outside resident rooms [ROOM NUMBERS], but no personal protective equipment (PPE) was available to put on prior to entering the rooms. During an interview on 3/05/25 at 8:37 a.m. in the sub-acute unit with Assistant Director of Nursing (ADON), the ADON stated PPE was located inside the resident rooms and acknowledged that per the signage, providers and visitors must put on gloves and gowns before entering the room. During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions Policy, dated 2024, the P&P indicated, Provide isolation cart with Personal Protective Equipment immediately outside resident room.

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50657 Based on observation, interview, and record review the facility failed to ensure the exhaust hoses of the portable air conditioning units (PACU) were properly installed as directed (not duct taped to the window frames) and filters were routinely cleaned according to manufacturer's guidelines (MFU) in 12 of 12 PACU's found inside Rooms 15, 20,21,22,23,24,25,26,27,28,30, and 32. This failure had the risk for entrapment in the event of a fire secondary to the windows becoming inoperable due to exhaust hoses duct taped to the window frames, with the potential for poor air quality as filters were not cleaned as directed. Findings: During an observation on 3/04/25 at 10:40 a.m. the slider kits (plastic frame where exhaust hoses are attached) of the PACUs, inside Rooms 15, 20, 21, 22, 23, 24, 25, 26, 27, 28, 30, and 32 were noted to be short in length, horizontally installed, and card boards were used to fill in the gaps in the windows. The sliders were then duct taped to the window frames, preventing the windows to be opened when needed. During a review of the PACUs MFU titled, Keystone KSTAP14B, indicated in part, the window slider kit can be fixed with a bolt. Further review of the MFU, showed a window diagram of a window that can still be closed and opened once the slider is fixed or bolted, with foam cut according to the slide kit's length and placed/attached to the sliding window edge. During a concurrent observation and interview on 3/06/25 at 3:40 p.m., with the facility's Maintenance Supervisor (MS) was asked how often the air filters were cleaned, and why the exhaust hoses were duct taped to the window frames preventing the windows to be opened, the MS stated the air filters on the PACUs are cleaned every three months. The MS was not able to present any documentation or a tracking method for the cleaning of air filters. The MS further stated, the slider kits the PACUs came with were for smaller windows and not for the facility windows size/type. During a concurrent interview and record review on 03/07/25 at 9:49 a.m. with the MS inside room [ROOM NUMBER], the PACU's MFU was reviewed with the MS. Under the section for Care and Maintenance, the MFU stated, Clean the air filter at least once every two weeks to prevent inferior fan operation because of dust .This unit has two filters. Take the upper filter out .Remove the lower filter .Wash the air filter by immersing in gently warm water (about 40 degrees Celsius/104 degrees Fahrenheit) with a neutral detergent. Rinse the filter and dry it in a [NAME] place. The MS stated he was unaware the PACU's had two filters or that cleaning had to be done every two weeks.