STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555071	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyview Care Center	2000 W Washington Bl Los Angeles, CA 90018

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** sBased upon interview and record review, the facility failed to: 1. Ensure smoke break weren't limited for one of 5 sampled residents (Resident 55). This deficient practice resulted in violating Resident 55's rights to smoke. Findings: During a review of Resident 55's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 55 was admitted to the facility on [DATE] with diagnoses which included cellulitis of the right lower limb (a bacterial infection of the skin and underlying tissues in the right lower leg), sepsis (a life-threatening blood infection), bacteremia (bacteria in the blood) and open wound to the right thigh. During a review of Resident 55's Minimum Data Set (MDS- a federally mandated resident assessment tool), the MDS indicated Resident 55 was cognitively intact. The MDS also indicated Resident 55 required substantial assistance with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During an interview, on 6/3/2025, at 11:27 a.m., with Resident 55, Resident 55 stated per the Director of Nursing (DON), she was only allowed to smoke one cigarette a day at 9:00 a.m Resident 55 stated she wanted to be able to smoke at her own preference. Resident 55 stated not being able to smoke at her leisure during smoke breaks resulted in her feeling angry. During an interview, on 6/5/2025, at 9:25 a.m., with the DON, the DON stated all residents who smoked at the facility was able to smoke during designated smoking times. The DON stated upon admission, Resident 55 was weak and had wounds. The DON stated she told Resident 55 that she was allowed to smoke 1 cigarette a day until her wounds began to heal. The DON stated the risk of limiting a resident's smoke preference could result in a restriction of resident's rights. During a review of the facility's policy and procedures (P&P), the P&P, titled Resident's Rights, revised 2/2021, indicated Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: m. exercise his or her rights as a resident of the facility.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Obtain a written informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) and conduct an interdisciplinary team (([IDT] - team members from different disciplines who come together to discuss resident care) meeting before initiation of a psychotropic drug (Any drug that affects brain activities associated with mental process and behavior) for resident with diagnosis of dementia (a progressive state of decline in mental abilities) for one of six sampled residents (Resident 35). This deficient practice had the potential for Resident 35 to receive unnecessary medications. Findings: During a review of Resident 35's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated, Resident 35 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 35's diagnoses included dementia, bipolar disorder (sometimes called manic-depressive disorder, mood swings that range from the lows of depression to elevated periods of emotional highs), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 35's History and Physical (H&P), dated 4/19/2025, the H&P indicated, Resident 35 did not have the capacity to understand and make decisions. During a review of Resident 35's Minimum Data Assessment ([MDS] - a resident assessment tool), dated 4/28/2025, the MDS indicated, Resident 35's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated, Resident 35 was totally dependent (helper does all of the effort) from staff with oral hygiene, toileting hygiene, and personal hygiene. During a review of Resident 35's Order Summary Report (a document containing active orders), dated 6/1/2025, the Order Summary Report indicated, the physician placed a telephone order on 5/20/2025 for Resident 35 to start on Depakote sprinkles (drug used to treat seizure and mood disorder) 125 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) to give two capsules once a day (9 a.m.) for bipolar disorder manifested by uncontrollable extreme mood swings causing anger interfering with daily activities. The Order Summary Report indicated, the physician placed a telephone order on 4/17/2025 for Resident 35 to start on risperidone (anti-psychotic medication used to treat several mental health conditions) 1 mg to give twice a day (9 a.m., and 5 p.m.) for schizophrenia manifested by uncontrollable anger causing to strike out. During a review of Resident 35's medication administration records ([MAR] - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) from 4/18/2025 to 6/3/2025, the MAR indicated, Resident 35 was given Depakote and risperidone. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/4/2025 at 1:40 p.m., with the Director of Nursing (DON), Resident 35's clinical records were reviewed. The DON stated, Resident 35's Informed Consent for Depakote and risperidone were not signed by the IDT. The DON stated, Resident 35 lacks capacity to give informed consent because he had a diagnosis of dementia. The DON stated there was no IDT meeting minutes that was completed before the initiation of Resident 35's psychotropic drug. The DON stated the IDT together with the psychiatrist (a medical doctor who specializes in the diagnosis, treatment, and prevention of mental health disorders), and physician should meet and discuss prior to administration of the proposed treatment for the psychotropic drug making sure that the medications were used appropriately and safely to residents with dementia. The DON stated long term use of psychotropic drugs can cause unwanted side-effects such as slow heart rate, dizziness, headache and could affect or alter residents behavior. During a review of the facility's undated, policy and procedure (P&P) titled, Lack of Capacity when Medical Interventions Requires Informed Consent, the P&P indicated, The facility shall conduct an interdisciplinary team review of the prescribed medical interventions prior to the administration of the medical intervention, except in the case of emergency. The P&P indicated when the resident lacks capacity for informed consent and a psychoactive medication are ordered by the physician, a bioethics meeting will be held. It will include the resident's physician, another physician along with the facility interdisciplinary team member.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observation and interview, the facility failed to: 1. Ensure the room's curtains and curtain rod was not broken for one of 5 sampled residents (Resident 79). This deficient practice resulted in a violation of Resident 79's right to privacy and a potential to result in a safety hazard. Findings: During a review of Resident 79's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 79 was admitted to the facility on [DATE] with diagnoses which included cerebral ischemia (insufficient blood flow to the brain), gastro-esophageal reflux disease (a digestive disease in which stomach acid or bile irritates the food pipe lining), neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet) and adult failure to thrive (an inability to sustain weight due to poor nutrition, leading to progressive decline). During a review of Resident 79's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 3/13/2025, the MDS indicated Resident 79's cognitive (thinking) skills were severely impaired. The MDS also indicated Resident 79 required substantial assistance with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent observation and interview, on 6/3/2025, at 10:10 a.m., with Resident 79, Resident 79's curtains were observed hanging from a bent curtain rod. Resident 79 stated the curtains and curtain rod had been in that condition for a while now. Resident 79 stated it caused him to feel violated as pedestrians on the street could see through his window. During an interview, on 6/5/2025, at 9:15 a.m., with the Maintenance Supervisor (MS), the MS stated he was responsible for repairing equipment and furnishings in the facility. The MS stated the curtain and curtain railing in Resident 79's room was not in good condition and did not promote a homelike environment. The MS stated he had fixed Resident 79's curtain and curtain rod. The MS stated the risk of not having Resident 79's curtain and curtain rod in good condition could result in a safety issue if the curtains and curtain rod fell on a resident. During a review of the facility's policy and procedures (P&P), titled Homelike Environment, revised 2/2021, the P&P indicated the facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting.

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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 - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a Minimum Data Set ([MDS] - a resident assessment tool) assessment was completed accurately for three of 19 sampled residents (Residents 6, 72, and 10) by failing to: 1. Ensure Resident 6's risperidone (anti-psychotic medication used to treat several mental health conditions) was encoded as anti-psychotic medication (a type of drug used to treat symptoms of psychosis) under MDS section N (N0415 High Risk Drug Classes - Use and Indication). 2. Ensure Resident 72's significant weight loss (loss of 5 percent ([%] - out of each 100) or more in the last month or loss of 10% or more in last 6 months) was encoded under MDS Section K (K0300 Weight Loss). 3. Ensure Resident 10 had accurate documentation in the MDS to reflect her use of Dabigatran Etexilate Mesylate ([anti-coagulant]- medication used to thin the blood). These deficient practices resulted in incorrect data being transmitted to the Center for Medicare and Medicaid Services (CMS) and had the potential to negatively affect the plan of care and services for Resident 6, 72, and 10). Findings: 1. During a review of Resident 6's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated, Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 6's diagnoses included paranoid schizophrenia (a complex psychiatric disorder characterized by distorted thinking and awareness), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), and major depressive disorder ([MDD] - a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 6's History and Physical (H&P), dated 4/17/2025, the H&P indicated, Resident 6 was able to make decisions for activities of daily living. During a review of Resident 6's MDS assessment, dated 4/23/2025, the MDS indicated, Resident 6's cognitive (ability to think and reason) skills for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated, Resident 6 was totally dependent (helper does all of the effort) from staff with toileting hygiene and upper and lower body dressing. During a review of Resident 6's Order Summary Report (a document containing active orders), dated 6/5/2025, the Order Summary Report indicated, the physician placed a telephone order on 4/16/2025 for Resident 6 to start on risperidone 2 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) to give one tablet two tines a day (9 a.m. and 5 p.m.) for paranoid schizophrenia manifested by extreme paranoid thoughts or hallucinations causing fear and stress interfering with daily living activities. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/4/2025 at 9:17 a.m., with the Minimum Data Set Nurse (MDSN), Resident 6's MDS assessment, dated 4/23/2025, was reviewed. The MDSN stated Resident 6's MDS assessment was completed inaccurately. The MDSN stated there should be a check marked on Section N0415 under anti-psychotic drug because Resident 6 was given risperidone from 4/17/2025 to 4/23/2025. The MDSN stated risperidone was classified as anti-psychotic medication. The MDSN stated it was important to encode each sections of the MDS accurately because it could affect the delivery of care and service provided by facility to residents. During a review of the facility's policy and procedure (P&P), titled Certifying Accuracy of the Resident Assessment, dated 11/2019, the P&P indicated, Any person completing a portion of the Minimum Data Set/MDS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment. 2. During a review of Resident 72's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated, Resident 72 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 72's diagnoses included congestive heart failure ([CHF] - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), anemia (a condition where the body does not have enough healthy red blood cells), and psychosis (a mental health condition characterized by a loss of touch with reality). During a review of Resident 72's History and Physical (H&P), dated 3/19/2025, the H&P indicated, Resident 72 did not have the mental capacity to understand and make medical decisions. During a review of Resident 72's Minimum Data Set ([MDS] - a resident assessment tool) assessment, dated 3/24/2025, the MDS indicated, Resident 72 was independent (decisions consistent/reasonable) in cognitive (ability to think and reason) skills for daily decision making. The MDS indicated, Resident 72 required moderate assistance (helper does less than half the effort) from staff with toileting hygiene and lower body dressing. During a review of Resident 72's Weights and Vitals Summary from 1/21/2025 to 3/18/2025, the Weights and Vitals Summary indicated the following: 1. On 1/21/2025 - 216 pounds ([lbs.] - unit of weight) 2. On 2/4/2025 - 209 lbs. 3. On 3/5/2025 - 173 lbs. (- 36 lbs./17.2 % significant weight loss in 1 month) 4. On 3/18/2025 - 169 lbs. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/6/2025 at 9:43 a.m., with the Minimum Data Set Nurse (MDSN), Resident 72's MDS assessment, dated 3/24/2025, was reviewed. The MDSN stated Resident 72's MDS was completed inaccurately. The MDSN stated Resident 72's MDS, Section K0300 was coded 0 (No), however, it should have been coded as 1 (Yes, on physician prescribed weight-loss regimen). The MDSN stated Resident 72 had a significant weight loss of 38 lbs. (17.2%) in 1 month from 3/5/2025 to 2/4/2025. The MDSN stated by not coding the accurate information on Resident 72's MDS assessment, the facility would not be able to provide the interventions to address resident's weight loss. The MDSN stated he will modify the MDS assessment immediately. During a review of the facility's P&P, titled Resident Assessments, dated 3/2022 indicated all persons who have completed any portion of the MDS assessment form must sign the document attesting to the accuracy of such information. c. During a review of Resident 10's admission Record, the admission Record indicated Resident 10 was admitted to the facility on [DATE], with a readmission on [DATE]. Resident 10's diagnoses included hypertension (HTN-high blood pressure), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and atrial fibrillation [A-Fib]- an irregular and often very rapid heart rhythm). During a review of Resident 10's History and Physical (H&P), dated 6/1/2025, the H&P indicated Resident 10 did not have the capacity to understand and make decisions. During a review of Resident 10's Minimum Data Set ([MDS] - a resident assessment tool) assessment, dated 4/30/2025, the MDS indicated Resident 10 needed maximal assistance with toileting, showering, eating, and dressing. The MDS indicated Resident 10 was not taking an anti-coagulant. During a review of Resident 10's Order Summary, dated 6/1/2025, the summary indicated on 3/1/2025 the physician entered an order to give Dabigatran Etexilate Mesylate 150 mg (a unit of measure for medication) twice a day. During a review of Resident 10's care plan, dated 1/24/2025, the care plan indicated Resident 10 was at risk for adverse effects of Dabigatran Etexilate Mesylate. During a concurrent interview and record review on 6/6/2025 at 10:55 a.m. with the Minimum Data Set Nurse (MDSN), Resident 10's MDS assessment was reviewed. The MDSN stated Dabigatran Etexilate Mesylate should be coded on the assessment as an anti-coagulant. The purpose of the MDS assessment is to gather information and document the current condition of the resident. It tells CMS what kind of care the facility is providing for the resident. Since the MDS assessment was not properly completed CMS does not have an accurate description of the resident's condition. During a review of the facility's policy and procedure (P&P) titled, Certifying Accuracy of the Resident Assessment, dated November 2019, the P&P indicated any person who completes any portion of the MDS assessment is required to sign the assessment certifying the accuracy of that portion of that assessment.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate services to prevent a decline in joint range of motion ([ROM] - full movement potential of a joint) for two out of two sampled residents (Resident 24 and 76) who had limited ROM by failing to: 1. Ensure 24 received timely quarterly (every three months) Joint Mobility Screening/Assessment to monitor changes in joint range of motion. 2. Ensure one of seven sampled residents (Resident 76) received passive range of motion ([PROM]- movement of a joint through its full range of motion without any effort from the individual) exercises seven days a week by the Restorative Nurse Assistant ([RNA]- a healthcare worker who helps residents improve and maintain function in physical abilities) as ordered by the physician. These deficient practices had the potential to cause further decline in Resident 24 and Resident 76's ROM and overall quality of life. Findings: 1. During a review of Resident 24's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated, Resident 24 was admitted to the facility on [DATE]. Resident 24's diagnoses included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), dementia (a progressive state of decline in mental abilities), and other abnormalities of gait and mobility. During a review of Resident 24's History and Physical (H&P), dated 9/27/2024, the H&P indicated, Resident 24 did not have the mental capacity to understand and make decisions. During a review of Resident 24's Minimum Data Set ([MDS] - a resident assessment tool), dated 4/4/2025, the MDS indicated, Resident 24's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated, Resident 24 required substantial assistance (helper does more than half the effort) from staff with toileting hygiene and upper and lower body dressing, and personal hygiene. The MDS indicated, Resident 24 had functional limitation in ROM on one side of upper extremity (shoulder, elbow, wrist, hand). During an observation on 6/3/2025 at 10:19 a.m., in the activity room, observed Resident 24 sitting in wheelchair, unable to fully extend her right upper extremity particularly the elbow. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/4/2025 at 9:37 a.m., with the Minimum Data Set Nurse (MDSN), Resident 24's clinical records, were reviewed. The MDSN stated Joint Mobility Screening/Assessment should be completed quarterly based on the MDS scheduled assessment, yearly and as needed. The MDSN stated Resident 24's last Joint Mobility Screening was completed on 9/26/2024 and another quarterly screening should have been completed on December 2024 and March 2025. The MDSN stated the purpose of completing the Joint Mobility Screening in a timely manner was to monitor resident's range of motion and if there was a decline then the resident could be a good candidate for active therapy services. During an interview on 6/4/2025 at 9:55 a.m., with the Director of Rehab (DOR), the DOR stated the quarterly Joint Mobility Screening for Resident 24 was not completed as scheduled. The DOR stated the rehabilitation staff was responsible in completing the Joint Mobility Screening to monitor contracture (stiffening/shortening at any joint, that reduces the joint's range of motion) and keep track of residents change in range of motion so the facility could provide interventions to prevent further contractures. During a review of the facility's undated policy and procedure (P&P) titled, Screening, the P&P indicated, Quarterly and Annual screens (both Rehabilitation and/or Joint Mobility Screening forms) may be done as per facility policy and in conjunction with the MDS assessment schedule. During a review of the facility's P&P titled Resident Mobility and Range of Motion. Dated 7/2017, indicated documentation of the resident's progress towards the goals and objectives will include attempts to address any changes or decline in the resident's condition or needs. During a review of the facility's P&P titled Functional Impairment - Clinical Protocol, dated 3/2018, indicated upon admission to the facility, whenever a significant change of condition occurs, and periodically during a resident's stay, the physician and staff will assess the resident's function along with their physical condition. b. During a review of Resident 76's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated Resident 76 was initially admitted to the facility on [DATE], with a readmission on [DATE]. Resident 76's diagnoses included dysphagia (difficulty swallowing), seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). During a review of Resident 76's History and Physical (H&P), dated 1/28/2025, the H&P indicated Resident 76 was able to make decisions for activities of daily living. During a review of Resident 76's Minimum Data Set ([MDS]- a resident assessment tool), dated 6/2/2025, the MDS indicated Resident 76's cognition (ability to understand and reason) was intact. The MDS indicated Resident 76 needed supervision bathing and dressing the upper body. During a review of Resident 76's Order Summary Report, dated 6/1/2025, the report indicated on 4/11/2025 the physician entered an order for the RNA to perform left upper extremity PROM every day seven times a week. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 76's care plan, dated 5/27/2024, the care plan indicated the facility would provide the RNA program as ordered to minimize decline in joint mobility. During a review of Resident 76's RNA task form for left upper extremity PROM every day seven times a week, dated 5/8/2025 through 6/5/2025, the task indicated PROM was provided on the following dates: 5/8/2025 5/9/2025 5/12/2025 5/13/2025 5/14/2025 5/15/2025 5/16/2025 5/20/2025 5/21/2025 5/22/2025 5/23/2025 5/26/2025 5/27/2025 5/28/2025 5/30/2025 6/2/2025 6/3/2025 6/4/2025 6/5/2025 (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/6/2025 at 11:19 a.m. with Licensed Vocational Nurse (LVN) 1, LVN1 stated RNA services are provided to keep the resident at their highest level of functioning. Providing PROM exercises prevents contractures. If PROM is not provided as ordered, the resident may become contracted. During a concurrent interview and record review on 6/6/2025 at 11:32 a.m. with RNA1, Resident 76's RNA task form for PROM was reviewed. RNA1 stated when a resident has an order for PROM seven times a week, it must be done every day. RNA1 stated Resident 76 did not receive PROM every day. RNA1 stated the purpose of RNA services are to help the resident move their bodies when they can't do it themselves or need assistance. Not completing the PROM as ordered put the resident at risk for decline. The resident can become contracted. During a review of the facility's policy and procedure (P&P) titled, Resident Mobility and Range of Motion dated July 2017, the P&P indicated residents with limited range of motion will receive treatment and services to prevent a further decrease in range of motion. Residents with limited mobility will receive appropriate services to maintain or improve mobility. During a review of the Restorative Nurse Assistant job description, the job description indicated the RNA's duties and responsibilities are to assist the resident with range of motion exercises per physician's orders to improve or maintain mobility and independence in the resident.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: 1. Ensure a peripheral catheter ([IV] - a thin tube inserted into a vein for therapeutic purposes such as administration of medications, fluids and/or blood products) was removed after IV antibiotic (a drug used to treat infections caused by bacteria) was completed for one of one sampled resident (Resident 57). This deficient practice had the potential for the IV insertion site to develop infection and/or hospitalization for Resident 57. Findings: During a review of Resident 57's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated, Resident 57 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 57's diagnoses included urinary tract infection ([UTI] - an infection in the bladder/urinary tract), dementia (a progressive state of decline in mental abilities), and type 2 Diabetes Mellitus ([DM] - a disorder characterized by difficulty in blood sugar and poor wound healing). During a review of Resident 57's Minimum Data Assessment ([MDS] - a resident assessment tool), dated 4/14/2025, the MDS indicated, Resident 57's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated, Resident 57 was totally dependent (helper does all of the effort) from staff with oral hygiene, upper and lower body dressing, and personal hygiene. During a review of Resident 57's Order Summary Report (a document containing active orders), dated 6/1/2025, the Order Summary Report indicated, the physician placed a telephone order on 5/29/2025 for Resident 57 to start on ceftriaxone (drug used to treat bacterial infection) 1 gram ([gm] - metric unit of measurement, used for medication dosage and/or amount) IV one time a day for UTI for 4 days. During a review of Resident 57's IV medication administration records ([MAR] - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), the IV MAR indicated, Resident 57's last dose of ceftriaxone 1 gm IV was given on 6/1/2025 at 4:30 p.m. During a concurrent observation and interview on 6/3/2025 at 2:28 p.m., with the Minimum Data Set Nurse (MDSN), in Resident 57's room, Resident 57 had an IV line on left hand. The MDSN stated, Resident 57's IV antibiotic was completed two days ago. The MDSN stated the licensed nurse who administered the last dose of IV antibiotic should have removed the IV peripheral catheter immediately to minimize discomfort and prevent infection. During a review of the facility's policy and procedure (P&P) titled, Peripheral Catheter Removal, dated 5/2023, the P&P indicated, Peripheral catheters are removed at the time completion of therapy.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview, and record review, the facility failed to: 1. Ensure accurate accounting/documentation of a controlled drug ([Lyrica]- medication used for nerve pain) for one out of seven sampled residents (Resident 21). This deficient practice had the potential to result in drug diversion. Findings: During a review of Resident 21's admission Record, the admission Record indicated Resident 21 was admitted to the facility on [DATE]. Resident 21's diagnoses included hypertension (HTN-high blood pressure), seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). During a review of Resident 21's History and Physical (H&P), dated 6/20/2025, the H&P indicated Resident 21 had the capacity to understand and make decisions. During a review of Resident 21's Minimum Data Set ([MDS]- a resident assessment tool), dated 6/4/2025, the MDS indicated Resident 21 needed moderate assistance with toileting, showering, eating, and dressing. During a concurrent interview and record review on 6/6/2025 at 10:59 a.m. with the Director of Nursing (DON), the facility's Controlled Medication Destruction Log was reviewed for Resident 21's Lyrica. The DON stated when a resident is discharged or a drug is discontinued, the nurse brings it to her and fills in the log indicating it was turned in. The DON then signs indicating the drug was received. The DON stated the purpose of signing the form is to keep track of where the medication is. The log indicated on 6/4/2025 the nurse turned in 28 Lyrica pills for destruction. There is no signature indicating who received the Lyrica. The DON stated she did not sign the form because the drug count was incorrect. Review of the medication bubble pack indicated there are 28 Lyrica pills remaining. Review of the Antibiotic or Controlled Drug Record form indicated there are 30 pills remaining. The DON stated the nurse gave the doses and did not document it upon administration. Both nurses should count the drugs during hand off at shift change. The hand off was not done correctly. During a concurrent interview and record review on 6/6/2025 at 12:07 p.m. with Licensed Vocational Nurse (LVN) 2, the facility's Controlled Medication Destruction Log was reviewed for Resident 21's Lyrica. LVN2 stated looking at the documentation you would not know where the drug is. It looks like the medication was displaced. This is not okay for a controlled drug. During a review of the facility's policy and procedure (P&P) titled, Medication Administration-General Guidelines, dated April 2008, the P&P indicated in no case should the individual who administered the medication report off-duty without first recording the administration of any medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Controlled Substances, dated April 2019, the P&P indicated controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift. The P&P indicated the nurse administering the medication is responsible for recording the tine of administration, quantity of the medication remaining, and signature of the nurse administering the medication. The P&P indicated disposal of controlled medications are done in the presence of the nurse and a witness who also signs the disposition sheet. During a review of the Licensed Vocational Nurse job description, the job description indicated the nurse will ensure medications are documented in a timely fashion and in accordance with the company's policies and procedures.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Ensure a pharmacy consultant (a professional responsible for reviewing each resident's medication profile monthly to identify and report changes) recommendation to consider ordering valproic acid level (test that measures the concentration of valproic acid, an anticonvulsant medication, in the blood) and ammonia level (test that measures the amount of ammonia level in the blood) was acknowledged and acted upon for one of five sampled residents (Resident 72). This deficient practice had the potential for Resident 72 to experience a delay in treatment. Findings: During a review of Resident 72's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated, Resident 72 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 72's diagnoses included congestive heart failure ([CHF] - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), anemia (a condition where the body does not have enough healthy red blood cells), and psychosis (a mental health condition characterized by a loss of touch with reality). During a review of Resident 72's History and Physical (H&P), dated 3/19/2025, the H&P indicated, Resident 72 did not have the mental capacity to understand and make medical decisions. During a review of Resident 72's Minimum Data Set (a resident assessment tool), dated 3/24/2025, the MDS indicated, Resident 72 was independent (decisions consistent/reasonable) in cognitive (ability to think and reason) skills for daily decision making. The MDS indicated, Resident 72 required moderate assistance (helper does less than half the effort) from staff with toileting hygiene and lower body dressing. During a review of Resident 72's Order Summary Report (a document containing active orders), dated 6/1/2025, the Order Summary Report indicated, the physician placed a telephone order on 3/18/2025 for Resident 72 to start on Depakote Delayed Release (drug used to treat seizure and mood disorder) 250 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) to give one tablet twice a day (9 a.m. and 5 p.m.) for mood disorder manifested by episodes of hallucination hearing someone is out to get him to do surgery on him. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/5/2025 at 1:31 p.m., with the Director of Nursing (DON), Resident 72's Consultant Pharmacist Medication Regimen Review (MRR), dated 4/24/2025, was reviewed. The MRR indicated, Please follow-up with doctor to consider ordering valproic acid and ammonia level. The DON stated the timeline to follow-up pharmacy consultant recommendation to physician is within 14 days after receiving the MRR report. The DON stated the facility failed to take any action on the consultant pharmacist recommendation by not informing Resident 72's physician. The DON stated there was no previous and current order to check valproic acid and ammonia level. The DON stated it is the facility's policy to address MRR by the pharmacy consultant for the welfare of the resident. The DON stated the purpose of checking valproic acid and ammonia level of Resident 72's was to check the therapeutic blood level (amount of a specific medicine or drug present in the blood stream at a particular time) in order to determine if the medication was safe to administer. The DON stated if Resident 72's valproic acid and ammonia level was not within the therapeutic range then his behavior would escalate (certain pattern of behavior that can get worse over time). During a review of the facility's policy and procedure (P&P), titled Consultant Pharmacist Reports, dated 12/2016, the P&P indicated, Recommendations are acted upon and documented by the facility staff and or the prescriber. The P&P indicated the physician accepts and acts upon suggestion or rejects and provides an explanation for disagreeing.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Ensure laboratory test (a medical procedure that analyzes a sample of blood, urine, or other bodily fluid or tissue) to check ammonia level (test that measures the amount of ammonia level in the blood) was completed monthly as ordered by the physician for one of 19 sampled residents (Resident 24). This deficient practice had the potential for Resident 24 not receiving necessary medical treatment. Findings: During a review of Resident 24's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated, Resident 24 was admitted to the facility on [DATE]. Resident 24's diagnoses included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), dementia (a progressive state of decline in mental abilities), and other abnormalities of gait and mobility. During a review of Resident 24's History and Physical (H&P), dated 9/27/2024, the H&P indicated, Resident 24 did not have the mental capacity to understand and make decisions. During a review of Resident 24's Minimum Data Set (a resident assessment tool), dated 4/4/2025, the MDS indicated, Resident 24's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated, Resident 24 required substantial assistance (helper does more than half the effort) from staff with toileting hygiene and upper and lower body dressing, and personal hygiene. During a review of Resident 24's Order Summary Report (a document containing active orders), dated 6/1/2025, the Order Summary Report indicated, the physician placed a telephone order on 1/30/2025 for Resident 24 to check ammonia level monthly. During a concurrent interview and record review on 6/4/2025 at 9:27 a.m., with the Minimum Data Set Nurse (MDSN), Resident 24's clinical records were reviewed. The MDSN stated Resident 24's laboratory tests as ordered by the physician on 1/30/2025 to check for ammonia level was not completed and results were not available. The MDSN stated there was no documentation indicating that the ammonia level for the month of March, April, and May 2025 were drawn. The MDSN stated elevated ammonia level could cause confusion and loss of consciousness. The MDSN stated it was important for Resident 24's ammonia level to be drawn to keep track of the therapeutic level (amount of a specific medicine or drug present in the blood stream at a particular time) so the physician could implement medical interventions. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P), titled Lab and Diagnostic Test Results - Clinical Protocol, dated 3/2023, the P&P indicated, The physician will identify, and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs and the staff will process test requisitions and arrange for tests.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Some	Dispose of garbage and refuse properly. Based upon observation and interview, the facility failed to: 1. Ensure 1 of 2 trash dumpster lids were closed. This deficient practice had the potential to result in unwanted pests and vermin. Findings: During a concurrent observation and interview, on 6/3/2025, at 9:25 a.m., with the Dietary Supervisor (DS), one trash dumpster lid was observed filled with trash and the lid was open. The DS stated all dumpsters were to remain closed. The DS stated the risk of having an open trash dumpster lid could result in a potential infestation for pests and vermin. During a review of the facility's undated policy and procedures (P&P), titled Waste Control and Disposal, the P&P indicated Trash bins should be covered at all times.

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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** Based on observation, interview, and record review, the facility failed to: 1. Ensure one of seven sampled residents (Resident 31) had enhanced barrier precautions ([EBP]- infection control strategy aimed at reducing the transmission of bacteria resistant to antibiotics) was implemented when care was provided to his feeding tube (a flexible plastic tube placed into the stomach to help you get nutrition when you're unable to eat). This deficient practice put Resident 31 at risk for infection. Findings: During a review of Resident 31's admission Record, the admission Record indicated Resident 31 was initially admitted to the facility on [DATE], with a readmission on [DATE]. Resident 31's diagnoses included hypertension (HTN-high blood pressure), dysphagia (difficulty swallowing), and malnutrition (a condition caused by not getting enough calories or the right amount of key nutrients). During a review of Resident 31's History and Physical (H&P), dated 9/19/2024, the H&P indicated Resident 31 had the capacity to understand and make decisions. During a review of Resident 31's Minimum Data Set ([MDS]- a resident assessment tool), dated 3/15/2025, the MDS indicated Resident 31 was dependent on staff for toileting, showering, dressing, and hygiene. During a review of Resident 31's care plan, dated 9/16/2024, the care plan indicated Resident 31 was at moderate risk for infection related to his feeding tube. The care plan indicated the facility would provide enhanced barrier precautions Gloves, Gowns, Masks. During an observation on 6/5/2025 at 9:25 a.m., there was an Enhanced Barrier Precautions sign located at the doorway of Resident 31's room and over his bed. The sign indicated staff must wear gloves and a gown when providing care or using a feeding tube. During an observation on 6/5/2025 at 9:26 a.m., Licensed Vocational Nurse (LVN) 1 was observed applying gloves, then injecting air into the feeding tube to check placement. LVN1 then aspirated fluid to check the feeding tube residual. LVN1 was not wearing a gown. During an interview on 6/5/2025 at 9:39 a.m. with LVN1, LVN1 stated EBP should be practiced when you are using a device such as a feeding tube. EBP includes performing hand hygiene and applying a gown and gloves. LVN1 stated she was not wearing a gown when she checked the G-tube residual because she forgot. LVN1 stated EBP prevents infection. LVN1 stated the resident is now at risk for infection because she did not wear a gown. During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, dated June 2024, the P&P indicated device care or use of a feeding tube is a high contact resident care activity requiring the use of gown and gloves for enhanced barrier precautions.