STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555211	A. Building B. Wing	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Extended Care Hospital of Westminster	206 Hospital Circle Westminster, CA 92683

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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** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the staff provided care and promoted dignity and respect for two of 21 final sampled residents (Residents 31 and 45) and five nonsampled residents (Residents 17, 27, 28, 33, and 84). * CNA 1 was observed assisting Residents 31 and 84 with meals at the same time. In addition, CNA 1 was observed assisting Resident 31 and 17 with meals at the same time. * CNA 2 was observed assisting 27 and 28 with meals at the same time. * CNA 3 was observed assisting Residents 33 and 45 with meals at the same time. These failures had the potential to negatively impact the residents' feelings of self-worth and well-being. Findings: Review of the facility's P&P titled Assistance with Meals revised 3/2022 showed the residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, by keeping interactions with other staff to a minimum while assisting residents with meals. 1. On 6/24/25 at 1230 hours, during the initial dining observation inside the dining room, CNA 1 was observed seated in between Residents 31 and 84. CNA 1 was observed feeding the two residents at the same time by alternating the placement of spoon and beverages to each resident. In addition, CNA 1 was observed touching the residents' bibs (clothes protector) during the feeding. On 6/24/25 at 1242 hours, another CNA took over to assist Resident 31 with feeding. CNA 1 assisted Resident 84 with feeding. CNA 1 was then observed taking Resident 84 out of the dining room when Resident 84 was done eating. On 6/24/25 at 1245 hours, CNA 1 was observed taking Resident 17 in the dining room. CNA 1 was observed taking Resident 17's tray from the cart and placed the lunch tray on the table where Resident 31 was seated. CNA 1 sat in between Residents 17 and 31. At this time, the other CNA assisting Resident 31 left. CNA 1 was observed continuing to assist Resident 31, then also assisted Resident 17 at the same time. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Medical record review for Resident 31 was initiated on 6/24/25. Resident 31 was readmitted to the facility on [DATE]. Review of Resident 31's MDS assessment dated [DATE], showed Resident 31 had severe cognitive impairment and was dependent on the facility staff with eating. b. Medical record review for Resident 84 was initiated on 6/24/25. Resident 84 was admitted to the facility on [DATE]. Review of Resident 84's MDS assessment dated [DATE], showed Resident 84 had severe cognitive impairment and needed substantial/maximal assistance from the facility staff with eating. c. Medical record review for Resident 17 was initiated on 6/24/25. Resident 17 was readmitted to the facility on [DATE]. Review of Resident 17's MDS assessment dated [DATE], showed Resident 17 had severe cognitive impairment and was dependent on the facility staff with eating. On 6/24/25 at 1452 hours, an interview was conducted with CNA 1. CNA 1 verified she assisted Residents 31 and 84 at the same time for feeding. CNA 1 stated she assisted Residents 31 and 84 who were both fully dependent on staff assistance with feeding. CNA 1 further stated when she was finished assisting Resident 84 with feeding, she brought in Resident 17. CNA 1 stated Resident 17 could hold her drinks, however, was fully dependent on staff assistance with feeding, so she assisted Resident 17 and also Resident 31 at the same time. CNA 1 stated this had been the practice in the facility. Cross reference to F880, example #1. 2. On 6/24/25 at 1235 hours, during the initial dining observation inside the dining room, CNA 2 was observed seated between Residents 27 and 28. CNA 2 was observed feeding the two residents at the same time by alternating the placement of spoon and beverages to each of the resident. a. Medical record review for Resident 27 was initiated on 6/24/25. Resident 27 was admitted to the facility on [DATE]. Review of Resident 27's MDS assessment dated [DATE], showed Resident 27 had severe cognitive impairment and needed substantial/maximal assistance from the facility staff with eating. b. Medical record review for Resident 28 was initiated on 6/24/25. Resident 28 was readmitted to the facility on [DATE]. Review of Resident 28's MDS assessment dated [DATE], showed Resident 28 had severe cognitive impairment and dependent on the facility staff assistance with eating. On 6/24/25 at 1444 hours, an interview was conducted with CNA 2. CNA 2 verified she assisted Residents 27 and 28 at the same time for feeding. CNA 2 stated the CNAs in the facility have been feeding two residents in the dining room at the same time and this has been the practice in the facility. Cross reference to F880, example #2. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 6/24/25 at 1239 hours, during the initial dining observation inside the dining room, CNA 3 was observed seated in between Residents 33 and 45. CNA 3 was observed feeding the two residents at the same time by alternating the placement of spoon and beverages to each resident. a. Medical record review for Resident 33 was initiated on 6/24/25. Resident 33 was admitted to the facility on [DATE]. Review of Resident 33's MDS assessment dated [DATE], showed Resident 33 had severe cognitive impairment and was dependent on the facility staff assistance with eating. b. Medical record review for Resident 45 was initiated on 6/24/25. Resident 45 was readmitted to the facility on [DATE]. Review of Resident 45's MDS assessment dated [DATE], showed Resident 45 had severe cognitive impairment and was dependent on the facility staff with eating. On 6/24/25 at 1456 hours, an interview was conducted with CNA 3. CNA 3 verified he assisted Residents 33 and 45 with feeding at the same time. CNA 3 stated Residents 33 and 45 were both dependent on the staff assistance with feeding. CNA 3 stated he was told the CNAs could feed two residents at the same time for as long as they sanitized their hands and the residents' hands before and after feeding. On 6/26/25 at 1116 hours, an interview was conducted with the DSD and LVN 1. The DSD stated the CNAs were trained to assist the residents with feeding. The DSD further stated the CNAs should be feeding one resident who was dependent on the staff with feeding, and another resident requiring only minimal assist, or just for cueing and actually able to feed themselves. When asked about the residents' assistance to eat, LVN 1 stated Residents 28, 31, 33, 45 and 84 were fully dependent on the staff assistance with eating, and Residents 17 and 27 could hold their cups, however, were fully dependent on the staff assistance with eating. The DSD stated they would have to check the seating arrangement to monitor any changes in the capability of the residents and the availability of the staff. Cross reference to F880, example #3.

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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** 4. Medical record review for Resident 397 was initiated on 6/24/25. Resident 397 was admitted to the facility on [DATE]. Review of Resident 397's admission Summary note dated 6/26/25 showed Resident 397 was admitted to the facility with diagnoses including bipolar disorder, anxiety disorder, and substance use disorder. Resident 397 had conservators to make medical decisions for him. Review of Resident 397's June 2025 Order Summary Report showed Resident 397 had the following orders dated 6/20/25: - buspirone (antianxiety medication) 10 mg by mouth twice daily for anxiety related to anxiety disorder - Haldol (antipsychotic) 10 mg inject intramuscularly as needed for any refusal of by mouth psychotropic medications for 14 days - Latuda (antidepressant) 80 mg by mouth in the evening for labile moods related to depression - Remeron (antidepressant) 30 mg by mouth at bedtime related to depression - Seroquel (antipsychotic) 100 mg every six hours as needed for increase psychosis related to bipolar disorder - Seroquel 100 mg by mouth three times daily for psychosis related to bipolar disorder - Vistaril (used off label to treat anxiety) 50 mg by mouth every four hours as needed for anxiety or agitation for 14 days - Wellbutrin (antidepressant) extended release 12 hour, give 100 mg by mouth in the morning for depressed mood related to depression - diphenhydramine (used off label to treat insomnia) 50 mg by mouth as needed for insomnia for 14 days at bedtime only Review of Resident 397's medication consent form dated 6/20/25, showed the following list of medications: - Remeron 15 to 45 mg - Latuda 40 to 160 mg - Wellbutrin 25 to 450 mg - Seroquel 50 to 1200 mg - Buspar 10 to 60 mg (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Haldol PO 0.5 to 80 mg - Haldol IM 100 mg/24 - benadryl IM 10 to 750 mg - Ativan PO/IM 1 to 10 mg - Vistaril 25 to 600 mg The from showed Resident 397's Physician 1 was supposed to discuss with Resident 397's Conservator 1 the information about the medications including; the nature of Resident 397's mental condition, reasons for prescribing the medication, reasonable alternative treatments available, side effects, and the right to refuse the medications. The medication consent form failed to show the exact dose, frequency, or reasons for prescribing the medications, as per Resident 397's Order Summary Report. On 6/26/25 at 0829 hours, a telephone interview was conducted with Conservator 1. When asked about receiving information and informed consent for Resident 397's psychotropic medications, Conservator 1 stated the process was the facility would fax the informed consent to the conservator's office for one of the conservators to sign or the facility would call the conservator and obtain verbal consent from a conservator, over the phone. When asked if questions related to the medications Resident 397 was prescribed arose, Conservator 1 stated the conservators could call and talk to the licensed nursing staff at the facility or could look for answers online. When asked if Physican 1 had contacted the Conservator's office to obtain informed consent for Resident 397's psychotropic medications, Conservator 1 verbalized, no. On 6/26/25 at 1056 hours, a concurrent interview and medical record review was conducted with Physician 1. Physician 1 verified Resident 397's medication consent form showed a list of Resident 397's psychotropic medications with a range of dosage for each medication. Physician 1 verified the form failed to show the exact dose, frequency, or reasons for prescribing the medications. When asked about his (Physician 1) signature next to each medication on this consent form, Physician 1 verbalized his signature next to each medication, meant he (Physician 1) was verifying the listed names of the medications and dosage range was correct. When asked about obtaining informed consent for these medications from Conservator 1, Physician 1 verified he did not call the conservator to obtain the informed consent for the use of the above medications. Based on interview, medical record review, and facility P&P review, the facility failed to ensure four of five sampled residents for unnecessary medications (Residents 19, 34, 36 and 43) and one final sampled resident (Resident 397) reviewed for informed consents were provided the right to self-determination regarding the use of psychotropic medications and treatments. * The facility failed to ensure the informed consents for risperidone (antipsychotic), Lexapro (antidepressant) and Belsomra (antidepressant) medications were renewed after six months for Resident 34. * The facility failed to ensure the informed consent for Seroquel (antipsychotic) medication was renewed after six months for Resident 19. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* The facility failed to ensure the facility's P&P for Psychotropic Medication Use was reviewed and revised to reflect the new regulation of renewing the informed consent for psychotropic medications every six months. * The facility failed to ensure Resident 36's informed consent for the use of the Remeron (antidepressant) medication was renewed after six months. * The facility failed to ensure the informed consent for Seroquel (antipsychotic) medication was renewed after six months for the use of antipsychotic medication for Resident 43. * The facility failed to ensure Resident 397's consent form for the use of Latuda (antipsychotic), Remeron (antidepressant), Wellbutrin (antidepressant), Seroquel (antipsychotic), Buspar (antianxiety), Haldol (antipsychotic), Benadryl (hypnotics/sedative/antianxiety), Ativan (antianxiety), and Vistaril (antianxiety) was updated to include the information about the medications' exact dose, frequesncy, or reasons for prescribing the medications. These failures posed the risk of the residents and their responsible party not understanding risks and benefits of psychotropic medications and the potential side effects. Findings: 1. Review of the AFL 24-07 titled AB 48 - Nursing Facility Resident Informed Consent Protection Act of 2023 dated 2/28/24, showed the following: - The facilities must renew the written informed consent every six months. At that time, the facility must provide the resident with any recommended dosage adjustments and the option of revoking consent; and - The facilities must review and revise their P&Ps to ensure compliance with the new law. The P&P must specifically consider and plan for how the facility will verify that the resident provided informed consent or refused treatment or a procedure pertaining to the administration of psychotherapeutic drugs. Review of the facility's P&P titled Antipsychotic Medication Use revised 7/2022 showed residents and/or resident representative will be informed of the recommendations, risks, benefits, purpose and potential adverse consequences of antipsychotic medication use. Review of the facility's P&P titled Psychotropic Medication Use revised 2/2025 showed medications in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, obtaining inform consent and review requirements specific to psychotropic medications: antipsychotics, antidepressants, antianxiety, and hypnotics/sedative. Medical record review for Resident 34 was initiated on 5/17/25. Resident 34 was readmitted to the facility on [DATE]. Review of Resident 34's Order Summary Report showed the following physician's orders: - dated 9/19/24, to administer Belsomra 10 mg by mouth at bedtime; (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 9/19/24, to administer Lexapro 10 mg by mouth one time a day; and - dated 12/4/24, to adminsiter risperidone 0.25 by moth every morning and at bedtime. Review of Resident 34's Verification of Informed Consent to Physical Restraints, Psychotherapeutic Drugs or Prolonged Use of a Device for Belsomra medication showed the resident/ responsible party was informed on 9/19/24, and the physician who has verbally indicated that consent has been obtained and the nurse who received the order signed on 9/19/24. Review of Resident 34's Verification of Informed Consent to Physical Restraints, Psychotherapeutic Drugs or Prolonged Use of a Device for Lexapro medication showed the resident/ responsible party was informed on 9/19/24, and the physician who has verbally indicated that consent has been obtained and the nurse who received the order signed on 9/19/24. Review of Resident 34's Verification of Informed Consent to Physical Restraints, Psychotherapeutic Drugs or Prolonged Use of a Device for risperidone medication showed the resident/responsible party was informed on 12/4/24, and the physician who has verbally indicated that consent has been obtained and the nurse who received the order signed on 12/4/24. On 6/27/25 at 1253 hours, an interview and concurrent medical record review for Resident 34 was conducted with LVN 1. LVN 1 verified the informed consents for Belsomra, Lexapro and risperidone medications were not renewed. LVN 1 stated the prescribing physician called the family or resident representative to obtain consent for the psychotropic medication. LVN 1stated the nursing staff filled out the Verification of Informed Consent form. LVN 1 further stated the informed consents should be renewed every six months. 2. Medical record review for Resident 19 was initiated on 6/24/25. Resident 19 was readmitted to the facility on [DATE]. Review of Resident 19's Order Summary Report showed the following physician's orders dated 9/18/24: - To administer Lexapro 20 mg one tablet by mouth one time a day; - To administer Seroquel 75 mg one tablet by mouth in the evening; and - To administer Seroquel 50 mg one tablet by mouth three times a day. Review of Resident 19's Verification of Informed Consent to Physical Restraints, Psychotherapeutic Drugs or Prolonged Use of a Device showed for Lexapro 20 mg the resident/ responsible party was informed on 3/7/24, and the physician has verbally indicated that consent has been obtained and the nurse who received the order signed on 3/7/24. Review of Resident 19's Verification of Informed Consent to Physical Restraints, Psychotherapeutic Drugs or Prolonged Use of a Device for Seroquel 50 showed the resident/responsible party was informed on 3/7/24, and the physician has verbally indicated that consent has been obtained and the nurse who received the order signed on 3/7/24. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 19's Verification of Informed Consent to Physical Restraints, Psychotherapeutic Drugs or Prolonged Use of a Device for Seroquel 75 mg showed the resident/responsible party was informed on 8/7/24, and the physician has verbally indicated that consent has been obtained and the nurse who received the order signed on 8/7/24. On 6/27/25 at 1302 hours, an interview and concurrent medical record review for Resident 19 was conducted with LVN 1. LVN 1 verified the informed consents for Seroquel 50 and 75 mg and Lexapro medications were not renewed every six months. On 6/27/25 at 1346 hours, an interview and concurrent medical record review for Residents 19 and 34 was conducted with the DON. The DON verified the above findings. The DON stated the nursing staff had to call the prescribing physician to obtain another informed consent every six months. The DON stated LVN 1 tracked the residents' physician orders and informed consents to check the informed consents which needed to be renewed. On 7/1/25 at 1022 hours, a follow-up interview and concurrent P&P review was conducted with the DON. The DON stated the facility reviewed the facility's P&Ps annually and as needed. The DON verified the facility's P&P for psychotropic medication use was not revised to reflect the new regulation to renew the informed consents every six months. 4. Review of the facility's P&P titled Informing Residents of Health, Medical Condition, and Treatment Options revised February 2021, showed each resident is informed of his/her total health status and medical conditions, including diagnosis, treatment recommendations, and prognosis in advance of treatment and on-going basis. If a resident has an appointed representative, the representative is also informed. Medical record review for Resident 43 was initiated on 6/27/25. Resident 43 was initially admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 43's H&P examination dated 11/1/24, showed Resident 43 had no capacity to understand and make decisions. Review of Resident 43's physician's order showed an order dated 10/31/24, to administer Seroquel (antipsychotic medication) 50 mg by mouth in the evening for psychosis (a mental disorder characterized by a disconnection from reality) manifested by impulsive behavior m/b restlessness difficulty being redirected. Review of the form titled Center Verification of Informed Consent to Physical Restraints, Psychotherapeutic drugs or Prolonged use of a Device for the use of Seroquel medication dated 10/31/24, showed the informed consent was obtained more than six months prior to the new order of the Seroquel medications dated 7/1/25. There was no documented evidence to show an informed consent for the use of an antipsychotic medication was renewed and discussed with Resident 43's responsible party after six months from the previous informed consent. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/1/25 at 0945 hours, an interview and concurrent medical record review for Resident 43 was conducted with LVN 1. LVN 1 was asked if LVN 1 was aware of the AFL 24-07 regarding the renewal of informed consent after six months for use of psychotherapeutic medications. LVN 1 stated being aware and had not renewed the informed consent. LVN 1 verified there was no renewal of the informed consent obtained for the use of the Seroquel medication. On 7/1/25 at 1010 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the findings and stated the informed consent will be renewed.3. Medical record review for Resident 36 was initiated on 6/24/25. Resident 36 was admitted to the facility on [DATE]. Review of Resident 36's H&P examination dated 10/14/24, showed Resident 36 had no capacity to understand and make decisions. Review of Resident 36's Verification of Informed Consent to Physical Restraints, Psychotherapeutic Drugs or Prolonged Use of a Device form dated 10/11/24, showed a consent was obtained from Resident 36's responsible party for the use of the Remeron (antidepressant, brand name for mirtazapine) 30 mg by mouth at bedtime for depression manifested by poor appetite. Review of Resident 36's Order Summary Report dated 6/25/25, showed a physician's order dated 11/6/24, to administer mirtazapine (antidepressant) 30 mg, one tablet by mouth at bedtime for depression manifested by insomnia. On 6/25/25 at 1453 hours, an interview and concurrent medical record review for Resident 36 was conducted with LVN 2. LVN 2 verified the above findings. LVN 2 stated there were no other consents for the use of the Remeron medication in Resident 36's medical record. On 6/26/25 at 1420 hours, an interview and concurrent medical record review for Resident 36 was conducted with LVN 1. LVN 1 stated the informed consent for the use of the psychotropic medications should include the medication, dose, route, frequency, diagnosis and behavior manifestations. LVN 1 stated for Resident 36 the dose and frequency for the psychotropic medication stayed the same and it was only the indication for the use of the medication was changed, so they did not need to have a new inform consent. LVN 1 reviewed Resident 36's medical record and stated Resident 36 was previously prescribed the Remeron medication for poor intake prior to his admission to the facility. LVN 1 further stated on 11/6/24, the indication for the use of the Remeron medication was changed to insomnia. LVN 1 stated Resident 36's responsible party was informed, however, a new informed consent was not obtained since the dose and the frequency of the Remeron medication was not changed. On 6/30/25 at 1536 hours, an interview was conducted with the DON. The DON stated if the physician's order for the psychotropic medications remained the same, the informed consent for the psychotropic medication should be renewed every six months. The DON further stated the desk nurse was responsible for calling the resident's family member and renew the informed consent every six months. On 7/1/25 at 1342 hours, the DON was informed and acknowledged the above findings.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 6. Review of the facility's P&P titled Psychiatric Pharmacy Policy dated 7/2/20, showed a standing order for Haldol (antipsychotic medication) 10 mg IM when residents refused to take any PO psychotropic medications. However, the policy did not mention nonpharmacological interventions that would be attempted prior to this standing order of residents refusing to take any PO psychotropic medications. Medical record review for Resident 397 was initiated on 6/24/25. Resident 397 was admitted to the facility on [DATE]. Review of Resident 397's admission Summary note dated 6/26/25, showed Resident 397 was admitted to the facility with diagnoses including bipolar disorder, anxiety disorder, and substance use disorder. Resident 397 had conservators to make medical decisions for him. Review of Resident 397's 6/2025 Order Summary Report showed Resident 397 had an order dated 6/20/25, for Haldol 10 mg, inject intramuscularly as needed for any refusal of by mouth psychotropic medications for 14 days. Further review of Resident 397's medical record failed to show what nonpharmacological interventions would be attempted prior to the administration of Resident 397's Haldol medication. On 6/27/25 at 1336 hours, an interview and concurrent medical record review for Resident 397 was conducted with LPT 1. When asked about Resident 397's Haldol medication use, LPT 1 verbalized the Haldol medication was a standing order for 14 days, for all the residents admitted to the facility. When asked about documented evidence as to what nonpharmacological interventions would be attempted prior to the administration of the Haldol medication, LPT 1 verified there was no documentation related to what nonpharmacological interventions would be attempted prior to the administration of the standing order for the Haldol medication. On 6/27/25 at 1355 hours, an interview and concurrent facility P&P review was conducted with the DON. The DON verified the findings. 5. Medical record review for Resident 19 was initiated on 6/24/25. Resident 19 was readmitted to the facility on [DATE]. Review of Resident 19's Order Summary Report showed the following physician's orders dated 9/18/24: - To administer Seroquel (antipsychotic medication) 75 mg one tablet by mouth in the evening; and - To administer Seroquel 50 mg one tablet by mouth three times a day. Review of Resident 19's MAR for 6/2025 showed Resident 19 was administered with Seroquel 75 mg from 6/1 to 6/26/25 at 1900 hours, and was administered Seroquel 50 mg from 6/1 to 6/26/25 at 0900, 1200, and 1700 hours, and 6/27/25 at 0900 and 1200 hours. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 19's medical record failed to show Resident 19 was monitored for the orthostatic hypotension while on the antipsychotic medications. On 6/27/25 at 1302 hours, an interview and concurrent medical record review for Resident 19 was conducted with LVN 1. LVN 1 verified the above findings. On 6/27/25 at 1346 hours, an interview and concurrent medical record review for Resident 19 was conducted with the DON. The DON stated when the nursing staff received an order for antipsychotic medication, the resident should be monitored for the side effects, black box warning, behavior manifestations, and orthostatic hypotension related to the use of the antipsychotic medications. 4. Review of the facility's P&P titled Blood Pressure, Measuring revised 9/2010 showed orthostatic (postural) hypotension is defined as a 20 mm/Hg (or greater) decline in systolic blood pressure or a 10 mm/Hg (or greater) decline in diastolic blood pressure upon standing. Hypotension should be reported to the physician. Staff should record several readings throughout the day, including before and after meals. Medical record review for Resident 43 was initiated on 6/24/25. Resident 43 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 43's H&P examination dated 11/1/24, showed Resident 43 had no capacity to understand and make decisions. Review of Resident 43's Order Summary Report for 6/2025 showed the following physician's orders: - order dated 10/31/24, to monitor orthostatic B/P while lying weekly everyday shift on Saturdays. - order dated 10/31/24, to monitor orthostatic B/P while sitting weekly everyday shift on Saturdays. Review of Resident 43's MAR for 6/2025 showed the following: - on 6/7/25, the BP readings were 128/67 mmHg for the sitting and lying position, - on 6/14/25, the BP readings were 133/76 mmHg for the sitting and lying position; and - on 6/121/25, the BP readings were 132/78 mmHg for the sitting and lying position. On 6/26/25 at 0910 hours, an interview and concurrent medical record review for Resident 43 was conducted with LVN 1. LVN 1 stated the orthostatic hypotension BP were checked weekly in lying, sitting, and standing position or per physician's orders. LVN 1 verified the above findings and stated the BP results should have changes in values. When asked how much of a drop in SBP and DBP would be considered orthostatic hypotension, LVN 1 stated a drop of 20 mmHg for both the SBP and DBP. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/25 at 1546 hours, an interview and concurrent medical record review for Resident 43 was conducted with LVN 3. LVN 3 verified the above findings. LVN 3 stated the orthostatic hypotension BP readings for lying and sitting were not accurate and should expect a difference in the BP readings. When asked how much of a drop in SBP and DBP readings would need to be reported to the physician, LVN 3 stated, I honestly can't tell you and what parameters to report, I don't know. On 7/1/25 at 0938 hours, an interview and concurrent medical record review for Resident 43 was conducted with the DON. The DON verified the above findings. The DON acknowledged Resident 43's MAR showed the resident's orthostatic hypotension BP readings for both lying and sitting were the same values. The DON stated the BP readings were not accurate and stated the BP readings for lying and sitting would have some differences in the BP readings. On 7/1/25 at 1419 hours, an interview was conducted with the Assistant Administrator and DON. The Assistant Administrator and DON were informed and acknowledged the above findings. Cross reference to F726. Based on interview, medical record review, and facility P&P review, the facility failed to ensure three of five sampled residents (final sampled residents, Residents 19, 36, and 43) reviewed for unnecessary medications, and three of 21 final sampled residents (Residents 1, 67, and 397) were free from unnecessary psychotropic medications. * The facility failed to ensure Resident 1's orthostatic blood pressure was monitored and accurately documented for the use of the Clozaril (antipsychotic) medication. * The facility failed to ensure Resident 36's orthostatic blood pressure was accurately monitored as ordered by the physician for the use of the risperidone (antipsychotic) medication. * The facility failed to ensure Resident 67's orthostatic blood pressure was accurately monitored as ordered by the physician for the use of the Seroquel (antipsychotic) medication. * The facility failed to ensure Resident 43's orthostatic hypotensive B/P lying and sitting were accurately monitored. B/P readings for lying and sitting were the same. Resident on Seroquel/Trazodone. * The facility failed to ensure Resident 19 who was on Seroquel medication was monitored for orthostatic hypotension. * The facility failed to document nonpharmacological interventions to be attempted prior to administering Resident 397's Haldol (antipsychotic) medication. * The facility failed to ensure Resident 397's consent included frequency, dose of med and MD obtained informed consent Findings: (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's P&P titled Antipsychotic Medication Use revised 12/2016, showed the nursing staff shall monitor for and report any of the following side effects and adverse consequences of the antipsychotic medications to the Attending Physician: a. General/anticholinergic: constipation, blurred vision, dry mouth, urinary retention, sedation; b. Cardiovascular: orthostatic hypotension (a condition where blood pressure drops suddenly when a person stands up from sitting or lying down), arrhythmia (an irregular heartbeat, where the heart beats too fast, too slow, or in an erratic rhythm); c. Metabolic: increase in total cholesterol/triglycerides, unstable or poorly controlled blood sugar, weight gain; or d. Neurologic: Akathisia (feeling of inner restlessness and an urge to move, often making it difficult to stay still), dystonia (involuntary muscle contractions), extrapyramidal effects (involuntary movements, muscle stiffness, and tremor), akinesia (loss or impairment of voluntary movement); or tardive dyskinesia (involuntary, repetitive, and rhythmic movements, often of the face and limbs), stroke or TIA (transient ischemic attack, a short period of symptoms similar to those of a stroke). Review of the facility's P&P titled Blood Pressure, Monitoring revised 9/2010 showed orthostatic hypotension is defined as a 20 mmHg (or greater) decline in the systolic blood pressure or a 10mmHg (or greater) decline in the diastolic blood pressure upon standing. 1. Medical record review for Resident 1 was initiated on 6/24/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's Medical Visit Note dated 5/2/25, showed Resident 1 had no capacity to understand and make decisions. Review of Resident 1's Order Summary Report dated 6/26/25, showed the following physician's orders: - dated 4/23/25, to check Resident 1's blood pressure in the sitting position, every Wednesday during the day shift, for the monitoring for orthostatic hypotension and to document on the weekly summary, - dated 4/23/25, to check Resident 1's blood pressure in the standing position, every Wednesday during the day shift, for the monitoring for orthostatic hypotension and to document on the weekly summary, - dated 6/13/25, to administer Clozaril 225 mg by mouth at bedtime for auditory hallucinations-preoccupied internal stimuli related to Schizophrenia a. Review of Resident 1's MAR for 6/2025 showed the following orthostatic BP readings: - on 6/4/25, the BP reading was documented as 86/39 mmHg for the sitting and the standing positions. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 6/11/25, the BP reading was documented as 104/51 mmHg for the sitting and the standing positions. - on 6/18/25, the BP reading was documented as 124/53 mmHg for the sitting and the standing positions. - on 6/25/25, the BP reading was documented as 123/70 mmHg for the sitting and the standing positions. b. Review of Resident 1's Weights and Vitals Summary for 6/2025 showed the following documentation of Resident 1's blood pressure readings: - on 6/4/25 at 0841 hours, Resident 1's blood pressure reading in the sitting position was 125/57 mmHg, and - on 6/4/25 at 0844 hours, Resident 1's blood pressure reading in the standing position was 86/39 mmHg. Further review of Resident 1's Weights and Vitals Summary for 6/2025 failed to show documentation Resident 1's blood pressure readings were retaken on 6/4/25 (for a 39 mmHg drop in the systolic and 18 mmHg drop in the diastolic blood pressure). Review of Resident 1's medical record failed to show documentation on 6/4/25, Resident 1 was assessed for the abnormal blood pressure reading of 86/39 mmHg, or the resident's physician was notified of the significant difference in Resident 1's orthostatic blood pressure readings for both the systolic blood pressure difference of 39 mmHg and diastolic blood pressure difference of 18 mmHg. On 6/26/25 at 1039 hours, an interview and concurrent medical record review for Resident 1 was conducted with LPT 1. LPT 1 stated the monitoring for orthostatic hypotension was done weekly for every resident in the TRC. LPT 1 stated the CNAs were responsible for taking the residents' vital signs including obtaining the resident's blood pressure readings in the sitting and standing positions (for the residents scheduled for monitoring for orthostatic hypotension). LPT 1 stated the vitals and orthostatic blood pressure readings were documented and recorded on the facility's TRC Change of Condition Log. LPT 1 stated the LPTs were responsible for reviewing the vital signs and checking to see if there was a drop in the blood pressure readings for the different positions. LPT 1 stated if there was a change of 10 mmHg or more in the systolic or the diastolic blood pressures, she would ask the CNA to recheck the blood pressure again, and document the rechecked blood pressure readings in the resident's medical record. LPT 1 stated upon recheck of the blood pressure readings, and a significant drop in the blood pressure was noted, the resident's physician would be notified. LPT 1 reviewed Resident 1's medical record and verified the above findings. LPT 1 stated the blood pressure reading of 86/39 mmHg was considered abnormal and in comparing the blood pressure readings for the sitting and standing positions, the difference in the systolic and the diastolic blood pressure readings were considered drastic. LPT 1 further stated the LPT who entered Resident 1's blood pressure into the MAR on 6/4/25 (86/30 mmHg), for the sitting and standing positions, should have caught the discrepancy and questioned the blood pressure reading. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/25 at 1101 hours, an interview and facility document review was conducted with Physician 1. Physician 1 reviewed the documented blood pressures obtained for Resident 1 on 6/4/25. Physician 1 stated if there was a drop in the orthostatic blood pressure readings, he expected the facility to further assess the resident for any symptoms and to retake the blood pressure readings. Physician 1 stated if the orthostatic blood pressure readings continued to show a drastic drop, indicating orthostatic hypotension, he expected to be informed. Cross reference to F726. 2. Medical record review for Resident 36 was initiated on 6/24/25. Resident 36 was admitted to the facility on [DATE]. Review of Resident 36's H&P examination dated 10/14/24, showed Resident 36 had no capacity to understand and make decisions. Review of Resident 36's Order Summary Report dated 6/25/25, showed the following physician's orders: - dated 10/11/24, to monitor Resident 36 for orthostatic hypotensive blood pressure in the lying position, every Saturday during the day shift, - dated 10/11/24, to monitor Resident 36 for orthostatic hypotensive blood pressure in the sitting position, every Saturday during the day shift, and -dated 6/24/25, to administer risperidone 0.25 mg by mouth daily for delusions manifested by stating people are trying to hurt him. Review of Resident 36's MAR for 6/2025 showed the following orthostatic BP readings: - on 6/7/25, the BP reading was documented as 130/78 mmHg for the sitting and the lying positions. - on 6/14/25, the BP reading was documented as 128/67 mmHg for the sitting and the lying positions. - on 6/21/25, the BP reading was documented as 132/76 mmHg for the sitting and the lying positions. On 6/25/25 at 1453 hours, an interview and concurrent medical record review for Resident 36 was conducted with LVN 2. LVN 2 stated the residents who were taking the psychotropic medications were monitored for orthostatic hypotension once a week. LVN 2 stated the monitoring for the orthostatic hypotension was done by obtaining the blood pressure readings in two different positions and comparing the two blood pressure readings to determine if there was a significant drop in the blood pressure, which could indicate orthostatic hypotension. LVN 2 reviewed Resident 36's medical record and verified the above findings. LVN 2 stated the blood pressure readings should not be the same. 3. Medical record review for Resident 67 was initiated on 6/24/25. Resident 67 was admitted to the facility on [DATE]. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 67's H&P examination dated 6/6/25, showed Resident 67 had no capacity to understand and make decisions. Review of Resident 67's Order Summary Report dated 6/25/25, showed the following physician's orders: - dated 5/24/23, to check Resident 67's blood pressure in the sitting position, every Wednesday during the day shift, for the monitoring for orthostatic hypotension and to document on the weekly summary, - dated 5/24/23, to check Resident 67's blood pressure in the standing position, every Wednesday during the day shift, for the monitoring for orthostatic hypotension and to document on the weekly summary, - dated 12/10/24, to administer Seroquel 200 mg by mouth at bedtime for paranoid ideations, anxiety, and difficulty sleeping related to schizoaffective disorder and mood disorder symptoms. Review of Resident 67's TRC Nursing Summary dated 6/3/25 at 1836 hours, showed the following documentation. Under nursing summary, the licensed nurse documented Resident 67's most recent blood pressure readings as follows: - the blood pressure for the sitting position was 121/78 mmHg, obtained on 6/3/25 at 0710 hours. - the blood pressure for the standing position was 123/88 mmHg, obtained on 6/3/25 at 1823 hours (more than 11 hours apart). Review of Resident 67's Weights and Vitals Summary for 6/2025 showed the following documentation of Resident 67's blood pressure readings: - on 6/3/25 at 0710 hours, Resident 67's blood pressure reading in the sitting position was 121/78 mmHg, and - on 6/3/25 at 1823 hours, Resident 67's blood pressure reading in the standing position was 123/88 mmHg. On 6/26/25 at 1039 hours, an interview and concurrent medical record review for Resident 67 was conducted with LPT 1. LPT 1 reviewed Resident 67's medical record and verified the above findings. LPT 1 stated when monitoring for the orthostatic hypotension, the blood pressure readings for the sitting and the standing positions should be obtained during the same encounter. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/30/25 at 1536 hours, an interview and concurrent medical record review for Resident 1 was conducted with the DON. The DON stated for the residents prescribed with psychotropic medications, the residents were monitored for the potential side effects such as orthostatic hypotension. The DON stated the monitoring for the orthostatic hypotension was done once every week during the same encounter, and the residents' blood pressures were obtained when they are in the lying and the sitting positions (and if the residents were able to stand, the blood pressure reading in the standing position would also be obtained), to determine if there was a drop in the blood pressure readings related to the position changes. The DON stated for the TRC unit, the CNA could obtain the resident's blood pressure readings for the sitting and standing positions, however the licensed nurses/technicians were responsible for reviewing the blood pressure readings and comparing the blood pressure readings and if there were any discrepancies, to address the discrepancies. On 7/1/25 at 1342 hours, the DON was informed and acknowledged the above findings.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview, medical record review, and facility P&P review, the facility failed to develop the care plan problems for the residents' plans of care as evidenced by: * The care plans were not developed for 23 of 23 residents in the TRC unit who smoked. * The facility failed to develop the comprehensive person-centered care plans for two of 21 final sampled residents (Residents 1 and 67) addressing the disputes on closing and leaving their door open. These failures had the potential risk of not providing the appropriate, consistent, and individualized care to the residents Findings: Review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered revised 12/2016 showed a comprehensive person-centered care plan will incorporate identified problem areas. 1. Medical record review for the list of smokers in the facility was initiated on 06/24/25. Review of the facility's document titled List of Smokers dated 6/24/25, showed the facility had 23 smokers. Review of the plans of care for the 23 residents listed on the smokers list failed to show care plan problems were developed to address the needs of the residents who smoked. For example: a. Medical record review for Resident 12 was initiated on 6/24/25. Resident 12 was admitted to the facility on [DATE]. Review of Resident 12's plan of care failed to show a care plan problem was initiated to address the resident was identified as a smoker and the risks associated with smoking. b. Medical record review for Resident 93 was initiated on 6/24/25. Resident 93 was admitted to the facility on [DATE]. Review of Resident 93's plan of care failed to show a care plan problem was initiated to address the resident was identified as a smoker and the risks associated with smoking. On 6/24/25 at 1154 hours, an interview and concurrent medical record review for the 23 residents who smoked in the TRC unit was conducted with the TRC Program Director. The TRC Program Director verified the findings. Cross reference to F689, example #1. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.a. Medical record review for Resident 1 was initiated on 6/24/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 5/2/25, showed Resident 1 had no capacity to understand and make decisions. Review of Resident 1's MDS assessment dated [DATE], showed a BIMS Summary score of 15, which meant Resident 1 was cognitively intact. Review of Resident 1's Skilled Notes dated 5/30/25, showed Resident 1 was overheard arguing with the roommate about keeping their door open. Resident 1 complained the roommate (Resident 67) went to take a shower and left the door open then returned and wanted it closed; however, Resident 1wanted it open. Resident 1 and the roommate were informed to keep the door half open and both agreed. Review of Resident 1's Behavior/Psychosocial Notes dated 6/10/25, showed during the medication pass administration, loud slamming of the door and yelling from Resident 1's room was overheard, the staff nearby explained Resident 1's roommate left the door open while Resident 1 was changing and Resident 1 became upset and slammed door shut. Resident 1's roommate then stepped out of room and stated, that lady is crazy. Resident 1's roommate was informed Resident 1 was changing, and the roommate left the door open. The documentation further showed after Resident 1 finished changing, Resident 1 was asked if she was okay and if she had any concerns, and Resident 1 responded sarcastically why wouldn't I be okay, if you have any concerns you can talk to someone else, and walked away. b. Medical record review for Resident 67 was initiated on 6/24/25. Resident 67 was admitted to the facility on [DATE]. Review of Resident 67's H&P examination dated 6/6/25, showed Resident 67 had no capacity to understand and make decisions. Review of Resident 1 and 67's care plan problem failed to show a care plan was initiated to address Residents 1 and 67's argument about closing and leaving the door open. Review of the facility's census in the TRC unit dated between 5/29 to 6/10/25, showed Residents 1 and 67 were roommates in Room A. On 6/24/25 at 0952 hours, an interview was conducted with Resident 67. Resident 67 was asked about the interaction she had with Resident 1, as roommates. Resident 67 stated they did not understand each other. On 6/27/25 at 0730 hours, an interview was conducted with LPT 3. LPT 3 was asked if prior to the reported alleged incident on 6/13/25, there were pre-existing issues between Residents 1 and 67. LPT 3 stated prior to the reported alleged incident, there was a dispute about leaving the door open and closed between Residents 1 and 67. LPT 3 added Resident 1 became upset and slammed the door. LPN 3 further stated there was a progress note about the incident and it was reported to the team in the morning during the shift report. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/30/25 at 1253 hours, an interview was conducted with the TRC Program Director. The TRC Program Director was asked about what the facility's protocol was when the residents had altercations or disputes between roommates. The TRC Program Director stated if there were any resident-to-resident disputes between roommates, the staff should see if it could be resolved and if something recurring, staff such as the MHW, nursing staff, TRC Program Director, and DON should look into the roommates and gather input from conservators. The TRC Program Director verified the facility staff should have attempted to resolve and develop care plan as needed if it was a recurring problem. On 7/1/25 at 1342 hours, an interview was conducted with the DON. The DON verified the above findings.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility document review, and facility P&P review, the facility failed to provide the individualized and ongoing activity program to meet the needs and interests of one of 21 final sampled resident reviewed for activities (Resident 49). * The facility failed to provide Vietnamese cultural music and TV program in the room for Resident 49 as per activities assessment. This failure had the potential for the resident to experience feelings of social isolation and frustration. Findings: Review for facility's P&P titled Activity Programs revised 6/2018 showed the following: - Activity programs are designed to meet the interest of and support the physical, mental and psychosocial well-being of each adult; - Activities offered are based on the comprehensive resident-centered assessment and the preferences of each resident; and - Individualized and group activities are provided that reflect the cultural and religious interests, hobbies, life experiences and personal preferences of the residents. On 6/24/25 at 0852 hours, Resident 49 was observed lying awake in bed. The TV was observed on a program in English language. A set of communication cards in a foreign language was observed hanging on the wall. Medical record review for Resident 49 was initiated on 6/24/25. Resident 49 was admitted to the facility on [DATE]. Review of Resident 49's H&P examination dated 11/9/24, showed Resident 49 had no capacity to understand and make medical decisions. Review of Resident 49's MDS assessment dated [DATE], showed Resident 49 had severe cognitive impairment and needed substantial/maximal assistance from the facility staff for mobility. Review of Resident 49's Activities - Initial Review dated 11/11/24, showed Resident 49's primary language was a foreign language, and only spoke the foreign language. The review form under the Current Activity Participation section, showed Resident 49 was to be with one-to-one staff, liked independent activities, and liked to listen to music in his primary language, and enjoyed sensory group. The Limitations/Special Needs section showed the activity staff were to provide cultural music in the resident's room or TV programs to promote therapeutic stimulation. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 49 's plan of care showed a care problem dated 11/12/24, to address Resident 49's dependence on staff for meeting emotional, intellectual, physical, and social needs. The interventions included the activity staff were to provide cultural music in the resident's room or TV programs to promote therapeutic stimulation and ensure the activities the resident attended were compatible with physical and mental capabilities, known interests and preferences, and individual needs and abilities. Review of Resident 49's Activities - Quarterly/Annual Participation Review dated 5/19/25, showed the resident's favorite activities included social, mental, and sensory stimulation and enjoyed social hours during activities, live entertainment, outdoor activities and cultural music. On 6/26/25 at 0838 hours, Resident 49 was observed lying awake in bed. The TV was observed on in English language. There was no radio observed in the room. On 6/26/25 at 0902 hours, an interview was conducted with CNA 4. CNA 4 stated Resident 49 spoke his primary language and was dependent on staff for his ADLs and activities. CNA 4 stated the activities staff turned the TV and radio on for Resident 49. On 6/26/25 at 0919 hours, an interview and concurrent medical record review for Resident 49 was conducted with the Activities Director. The Activities Director stated Resident 49 did not actively participated in the activities but was an observer who looks on, non-verbal but with social awareness. The Activities Director stated Resident 49 preferred cultural music and TV, which meant providing music and TV programs in his primary language. Review of Resident 49's Activity Participation Record for May and June 2025, showed Resident 49 was provided verbal participation/social, entertainment/music, current events/coffee social/ and lobby time/outing/OOP daily from 5/1 to 6/25/25. When asked about what activities were provided for Resident 49, the Activities Director stated they provided current events such as the TV news program, entertainment/music from radio or TV, and verbal participation or social meant when the activities staff talked or socialize with the resident when they visited the resident in the room. When asked what cultural music in the room was provided in the resident's room, the Activities Director stated they provided cultural music and events in the activities room. On 6/26/25 at 0925 hours, an observation and concurrent interview for Resident 49 was conducted with the Activities Director. Resident 49 was observed awake and lying in bed, The TV was observed on in English language. There was no radio in the room. A set of communication cards in a foreign language was observed hanging on the wall. The Activities Director verified the TV was on but not in the resident's primary language. When asked if they have provided any cultural music in the room or TV programs in the room per the resident's activities assessment, the Activities Director stated she was not sure why there was no radio in the resident's room and the facility did not have any TV channels in resident's primary language.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of 21 final sampled residents (Resident 49) remained free of accident hazards and four smokers were provided adequate supervision as evidenced by: * The facility failed to ensure the safety and supervision were provided during smoking times for four residents who were smoking. * The facility failed to ensure Resident 49's right floor mat was placed near the resident's bed. In addition, the facility failed to monitor resident's BP while lying, sitting and standing as per the care plan to address the fall that occurred on 5/21/25. Furthermore, Resident 49 was assessed to have changes from clear to rambling speech as per the neurocheck for the fall on 5/27/25; however, the facility failed to notify the physician for the changes in the resident's neurological status. These failures put the residents at risk for injuries. Findings: Review of the facility's P&P titled Designation of Smoking Areas and Rules of Smoking in Facility dated 5/2/24, showed the facility did not provide any staff supervised smoke breaks. 1. On 6/24/25 at 1154 hours, an observation of the smoking area and concurrent interview was conducted with the TRC Program Director. When asked about the facility's smoking policy for the residents who smoked, the TRC Program Director verbalized the smoking area was located outside the facility. The smoking area was observed to have benches and ashtrays. According to the TRC Program Director, the residents who had passes to go out of the facility were allowed to smoke unsupervised in the smoking area. There was no fire extinguisher or smoking apron observed in the smoking area. When asked if the residents were assessed to ensure the residents were safe to smoke unsupervised, the TRC Program Director verbalized the residents were asked whether or not they smoked, however, were not assessed to determine if they were safe to smoke unsupervised. On 6/25/25 at 1230 hours, an observation of the smoking area and concurrent interview was conducted with the Assistant Administrator and TRC Program Director. The smoking area was observed with a total of four residents smoking and unsupervised by the staff. The smoking area was observed to have a lawn area, trees, and bushes near the smoking area. Both the Assistant Administrator and TRC Program Director verified there was no fire extinguisher, smoking apron, or smoking blanket near the smoking area to use in case of a fire. In addition, the Administrator and TRC Program Director verified the four residents were observed smoking unsupervised and were allowed to smoke unsupervised. 2. Review of the facility's P&P titled Neurological Assessment (Routine) revised 10/2023 showed the following: - Routine neurological assessment is conducted to evaluate the resident for small changes over time that may be indicative of neurological injury; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Routine neurological exams include assessing the mental status, level of consciousness, pupillary response, motor strength, sensation and gait; and - To notify the physician for any changes in a resident's neurological status. Medical record review for Resident 49 was initiated on 6/24/25. Resident 49 was admitted to the facility on [DATE]. Review of Resident 49's H&P examination dated 11/9/24, showed Resident 49 had no capacity to understand and make decisions. a. Review of Resident 49's SBAR Communication Form and Progress Note dated 5/20/25, showed a CNA observed Resident 49 on the floor lying on the left side. Review of Resident 49's plan of care showed a care plan initiation dated 5/20/25, to address Resident 49's unwitnessed fall from the bed. The interventions included monitoring the vital signs and taking resident's blood pressure lying/sitting/standing for one time in the first 24 hours. Further review of Resident 49's medical records failed to show Resident 49's blood pressure was taken and monitored while lying, sitting, and standing. b. Review of Resident 49's SBAR Communication Form and Progress Note dated 5/27/25, showed a CNA observed Resident 49's legs swung to the right side and resident fell onto the floor pads. Review of Resident 49's plan of care showed a care plan dated 5/27/25, to address Resident 49's witnessed fall from the bed. The interventions included 24-hour neuro-checks and continued with low bed with floor pads and bed alarm. Review of Resident 49's MAR for 5/2025 showed Resident 49 was assessed for the vital signs, hand grasp, level of consciousness, movement, pupil, and speech every 15 minutes for the first hour, and every 30 minutes for the following two hours, then Resident 49 was assessed for vital signs, level of consciousness and pupil every two hours for 21 hours for a total of 24 hours of neurocheck. Further review of the MAR showed Resident 49 was assessed to have a clear speech following a fall on 5/27/25, at 0850, 0905, 0920, 0935, at 1005 hours. However, Resident 49 was assessed to have a rambling speech on 5/27/25 at 1035, 1105, 1135, and 1205 hours, and there were no subsequent assessments of Resident 49's speech. Further review of Resident 49's medical records failed to show Resident 49's speech was monitored nor was the physician notified of the changes in Resident 49's neurological status particularly the change in his speech. On 6/26/25 at 0838 hours, Resident 49 was observed lying awake in bed. The left floor pad was placed near the resident's bed; however, the right floor pad was not placed near the bed. On 6/26/25 at 0902 hours, an interview was conducted with CNA 4. CNA 4 stated Resident 49 spoke his primary language. CNA 4 stated Resident 49 kept on moving his arms and his legs. CNA 1 stated Resident 49 had fallen twice last month, and the fall prevention interventions included for bed alarm, placing bilateral floor pads, and making sure Resident 49's bed was in the lowest position. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/25 at 0909 hours, an observation for Resident 49 and concurrent interview was conducted with CNA 1. Resident 49 was lying awake in bed. CNA 1 verified the left floor pad was placed near the resident's bed; however, the right floor pad was not placed near the bed. On 6/26/25 at 0935 hours, an interview was conducted with RN 1. RN 1 stated Resident 49 was being monitored for restlessness and attempting to get out of bed. RN 1 stated Resident 49 could shift his weight while in bed, so he had a fall, and the interventions included placing the bilateral floor pads and making sure Resident 49's bed was in lowest position. When asked how they monitored the fall prevention interventions were in place, RN 1 stated the nursing staff did their rounds, and made sure Resident 49 had his bed in low position and had the bilateral floor pads. On 6/26/25 at 1008 hours, an interview and concurrent medical record review for Resident 49 was conducted with LVN 1. LVN 1 stated Resident 49 had an unwitnessed fall on 5/21/25. LVN 1 verified the care plan interventions for the fall on 5/21/25, included monitoring the vital signs, and taking resident's blood pressure lying/sitting/standing for one time in the first 24 hours. LVN 1 verified Resident 49's blood pressure was not taken and monitored while lying, sitting, and standing. LVN 1 stated they only monitored the vital signs, but this intervention was part of the interventions they clicked when developing the care plan to address the fall. LVN 1 further stated Resident 49 had a witnessed fall on 5/27/25. When asked about Resident 49's neurocheck assessment including speech, LVN 1 verified Resident 49's speech was initially clear but later became rambling. LVN 1 verified the physician was not notified when there was a change in Resident 49's speech. On 6/26/25 at 1542 hours, an interview and concurrent medical record review for Resident 49 was conducted with the DON. When asked about monitoring Resident 49's BP while lying, sitting, and standing for one time as per the care plan to address a fall on 5/21/25, the DON verified this was not done. The DON stated this intervention was part of the choices of pre-programmed interventions in the electronic health care record system. The DON stated the nurses might have clicked the intervention to monitor Resident 49's vital signs but did not delete to not include taking the resident's BP while lying, sitting and standing. The DON stated the nurses should have made the care plan interventions individualized and to be careful with the interventions in the resident's care plan because the expectation was to implement these care plan interventions. The DON stated a neurocheck was conducted for 24 hours for the residents who had a fall and monitored for 72 hours. The DON stated the physician should be notified of any changes in the resident's condition. The DON verified Resident 49's speech was initially clear but later became rambling per the neurocheck conducted due to a fall on 5/27/25. The DON stated she was not sure why the nurse documented Resident 49's speech changed from clear to rambling in the neurocheck assessment. The DON verified the physician was not notified when there was a change in Resident 49's speech.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary GT care and services for two of three final sampled residents (Residents 16 and 42) reviewed for GT feeding. * The facility failed to ensure the GT feeding formulas were not stored at bedside and the GT formula labels were accurate and matched the physician's orders for Residents 16 and 42. These failures posed the risk of misleading information on the residents' GT feeding rate and could lead to overfeeding or underfeeding, and storing a feeding formula at bedside posed a risk of contamination and spoilage, and increased risk of unauthorized access of the feeding formula. Findings: 1. Review of the facility's P&P titled Enteral Feedings - Safety Precautions revised 5/2014 showed to store unopened liquid enteral formulas in temperature and light-controlled conditions (cool, [NAME] from direct sunlight). The Preventing Errors in Administration section showed the following: - To check the enteral nutrition label against the order before administration, and to check the following information: resident name, ID and room number, type of formula, date and time formula was prepared, route of delivery, access site, method, and rate (ml/hour); and - On the formula label, document initials, date and time the formula was hung/ administered, and initial that the label was checked against the order. On 6/24/25 at 0912 hours, during the initial tour of the facility, Resident 16 was observed in bed, with GT feeding infusing via a feeding pump at 45 ml/hr. The feeding formula of Diabetisource was dated 6/24/25 (with no time to show when the bag was hung) and the rate written on the label was 44 ml/hr. An unopened bag of Diabetisource was also observed on the resident's nightstand, labeled with the resident's name, and a rate of 44 ml/hr. Medical record review for Resident 16 was initiated on 6/24/25. Resident 16 was readmitted to the facility on [DATE]. Review of Resident 16's Order Summary Report showed a physician's order dated 5/28/25, to administer Diabetisorce at 45 ml/hr for 21 hours to provide 945 ml /1134 kcal. On 6/24/25 at 0948 hours, an observation for Resident 16 and concurrent interview was conducted with LVN 1. LVN 1 verified the rate written on the label on Resident 16's GT formula did not match the physician's order. LVN 1 also verified there was an unopened bag of Diabetisource at Resident 16's bedside, with a wrong label. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 6/24/25 at 0928 hours, during the initial tour of the facility, Resident 42 was observed in bed, with GT feeding infusing via a feeding pump at 55 ml/hr. The feeding formula of Jevity 1.5 was dated 6/24/25 at 0215 hours, and the rate written on the label was 60 ml/hr. An unopened bag of Jevity 1.5 ml was also observed on the resident's overbed table near the window, and the feeding formula was labeled with the resident's name, and a rate of 60 ml/hr. Medical record review for Resident 42 was initiated on 6/24/25. Resident 42 was readmitted to the facility on [DATE]. Review of Resident 42's Order Summary Report showed a physician's order dated 4/23/25, to administer Jevity 1.5 at 55 ml/hr for 20 hours to provide 1100 ml/1650 kcal. On 6/24/25 at 0951 hours, an observation for Resident 42 and concurrent interview was conducted with LVN 1. LVN 1 verified the rate written on the label on Resident 42's GT formula did not match the physician's order. LVN 1 also verified there was an unopened bag of Jevity 1.5 at Resident 42's bedside, with a wrong label. On 6/24/25 at 0821 hours, an interview and concurrent medical record review for Residents 16 and 42 was conducted with the DON. When asked about the labels on the GT feeding formulas, the DON stated the GT feeding formula should be labeled with the resident's room, name, rate per the physician's order, and the date and time when the GT feeding formula was hung. The DON further stated it was important to label the GT feeding formula to confirm it was for the correct resident, correct rate, and to confirm what feeding formula was to be infused. When asked about the storage of the GT feeding formulas, the DON stated the feeding formulas were stored inside the utility room, and the utility room was locked and monitored for the temperature in the room. The DON further stated it was the practice of the night shift nurses to leave an extra unopened bag of the feeding formula for the morning shift nurses.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to provide the adequate and appropriate pain management for two of three final sampled residents (Resident 20 and 67) reviewed for pain management. * The facility failed to ensure the pain medication was administered as per the physician's orders for Resident 20. * The facility failed to ensure the non-pharmacological pain interventions were implemented and documented before the administration of the PRN pain medication for Resident 67. These failures had the potential for residents not to receive the appropriate treatment for pain. Findings: Review of the facility's P&P titled Pain Assessment and Management revised 3/2015 showed pain management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals. Non-pharmacological interventions may be appropriate alone or in conjunction with medications. Some non- pharmacological interventions include pharmacological interventions (such as pain medications) may be prescribed to manage pain; however, they do not usually address the cause of pain and can have adverse effects on the resident. The physician and staff will establish a treatment regimen based on consideration of the resident's medical condition and current medication regimen. The P&P further showed to document the resident's reported level of pain with adequate detail (enough information to gauge the status of pain and the effectiveness of intervention for pain) as necessary and in accordance with the pain management program. 1. Medical record review for Resident 20 was initiated on 6/24/25. Resident 20 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 20s H&P examination dated 12/20/24, showed Resident 20 did not have the capacity to understand and make decisions. Review of Resident 20's MAR for 5/2025 showed the resident received Tylenol pain medication as needed on 5/22/25 at 0158 hours for a pain level of five (on a 0-10 pain scale with 0 = no pain and 10 = worst pain). Review of Resident 20's Order Summary Report for 6/2025 showed the following physician's orders: - dated 9/24/20, for Tylenol 325 mg (pain medication) give two tablets via GT every six hours as needed for mild generalized pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/25 at 1433 hours, an interview and concurrent medical record review for Resident 20 was conducted with LVN 2. LVN 2 verified the above findings. LVN 2 stated Resident 20's pain level of five documented on the MAR dated on 5/22/25, was considered moderate pain. LVN 2 verified Resident 20 did not have pain medications ordered for moderate pain and the PRN Tylenol order was for mild pain. LVN 2 stated the physician should have been contacted to obtain a different medication order to address Resident 20's moderate pain. On 7/1/25 at 0938 hours, an interview and concurrent medical record review for Resident 20 was conducted with the DON. The DON verified the above findings and stated a pain level of one to three was mild pain, four to six was moderate pain, and seven to ten was severe pain. The DON further stated the pain medication will be effective if it was the accurate strength and dose and stated the license nurse should have called the physician for a pain medication to address the resident's moderate pain level. On 7/1/25 at 1419 hours, an interview was conducted with the Assistant Administrator and DON. The Assistant Administrator and DON were informed and acknowledged the above findings. 2. Medical record review for Resident 67 was initiated on 6/24/25. Resident 67 was admitted to the facility on [DATE]. Review of Resident 67's H&P examination dated 6/6/25, showed Resident 67 had no capacity to understand and make decisions. Review of Resident 67's Order Summary Report dated 6/25/25, showed a physician's order dated 5/24/23, to administer Tylenol (over the counter pain and fever reducer) 650 mg by mouth every four hours as needed for pain, headache, or temperature greater than 101 degrees F. Review of Resident 67's MAR for 6/2025 showed Resident 67 was administered the Tylenol 650 mg medication by mouth every four hours as needed on the following dates and times: - On 6/3/25 at 0715 hours, for a pain level of 8. - On 6/6/25 at 0955 hours, for a pain level of 5. - On 6/11/25 at 0910 hours, for a pain level of 8. - On 6/20/25 at 1006 hours, for a pain level of 6. - On 6/21/25 at 1140 hours, for a pain level of 6. - On 6/23/25 at 1156 hours, for a pain level of 8. However, review of Resident 67's medical record failed to show the documentation of the non-pharmacological pain interventions attempted prior to the administration of the Tylenol pain medications for the above dates and times. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/25 at 1553 hours, an interview and concurrent medical record review for Resident 67 was conducted with LPT 2. LPT 2 stated when the residents reported pain, the non-pharmacological pain interventions were attempted and its effectiveness was documented. LPT 2 stated if the resident refused the non-pharmacological pain interventions, the LPT would document the resident's refusal in the resident's progress notes. LPT 2 stated if the non-pharmacological pain interventions were not effective, the pharmacologic interventions would then be provided. LPT 2 reviewed Resident 67's medical record and verified the above findings. LPT 2 stated the non-pharmacological pain interventions should have been documented. On 6/30/25 at 1536 hours, an interview was conducted with the DON. The DON stated when the residents reported pain, the licensed nurses were expected to implement the non-pharmacological pain interventions and document its effectiveness. The DON stated if the nonpharmacological pain interventions were not effective, the licensed nurses should administer the PRN pain medication. The DON stated the non-pharmacological pain interventions should be implemented prior to the administration of the PRN pain medication to reduce the unnecessary use of pharmacological medications. The DON stated if the non-pharmacological pain interventions were effective, then the pharmacological medications would not be needed. The DON stated the facility protocol also applied to the TRC unit and prior to to the administration of the PRN pain medication, the nonpharmacological pain intervention should be implemented and documented. On 7/1/25 at 1342 hours, the DON was informed and acknowledged the above findings.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the competency of the licensed nurses on obtaining and evaluating the orthostatic hypotension as evidence by: * The facility failed to provide in-services and conduct the competency evaluations for the orthostatic hypotension monitoring as verified by the DON. * The facility failed to ensure the competency of the licensed nurses (LVNs 1 and 3, and LPTs 1 and 2) in obtaining and evaluating for orthostatic hypotension. These failures had the potential to put the residents at risk for the care not provided in a safe and competent manner. Findings: Review of the facility's P&P titled Blood Pressure, Measuring revised 9/2010 showed orthostatic (postural) hypotension is defined as a 20 mm/Hg (or greater) decline in systolic blood pressure or a 10 mm/Hg (or greater) decline in diastolic blood pressure upon standing. Hypotension should be reported to the physician. 1. Review of the facility document titled Facility 1 Change of Condition Log dated 6/10/25, showed Resident 35's BP sitting was 115/84 mmHg and BP standing was 98/65 mmHg. Further review of the facility's document showed Resident 35's orthostatic hypotension reading had a DBP difference of 19 mmHg. Review of the facility document titled Facility 1 Change of Condition Log dated 6/11/25, showed Resident 80's BP sitting was 111/71 mmhg and BP standing was 110/59 mmHg. Further review of the facility's document showed Resident 80's orthostatic hypotension reading had a DBP difference of 12 mmHg. Review of the facility documents titled Facility 1 Change of Condition Log dated 6/24/25, showed Resident 35's BP sitting was 114/80 mmHg and BP standing was 112/69 mmHg. Further review of the facility's document showed Resident 35's orthostatic hypotension reading had a DBP difference of 11 mmHg. Review of the facility document titled Facility 1 Change of Condition Log dated 6/24/25, showed Resident 63's BP sitting was 143/89 mmHg and BP standing was 142/77 mmHg. Further review of the facility's document showed Resident 63's orthostatic hypotension reading had a DBP difference of 12 mmHg. On 6/30/25 at 0938 hours, an interview and concurrent facility document review was conducted with Nurse Consultant 1. Nurse Consultant 1 stated the facility provided an annual competency for the TRC staff; however, the competency was conducted on 6/27/25 to 6/29/25. When asked to review last year's annual competency for staff on the TRC, Nurse Consultant 1 stated she could not provide the requested document. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/30/25 at 1005 hours, an interview was conducted with the Assistant Administrator. The Assistant Administrator stated the annual clinical competencies for the staff in the TRC unit were not assessed and verified. There were no documented evidence the competency evaluations were done. The Assistant Administrator further stated the DON for the TRC should have conducted the annual competencies for the staff in the TRC. The Assistant Administrator stated assessing for the staff competencies ensured the staff were clinically competent to care for the residents who required certain monitoring of their vital signs and clinical care. On 6/30/25 at 1554 hours, an interview and concurrent facility document review for Residents 35, 63, and 80 was conducted with the DON. The DON verified the above findings. The DON verified there was no documented evidence of a change of condition or nursing documentation was completed. The DON further stated the licensed nurses or LPTs were responsible for reviewing the BP readings and comparing the values to determine if there were discrepancies in the BP readings and to address those discrepancies. On 7/1/25 at 1410 hours, an interview was conducted with the DSD. When asked if the licensed nurses were assessed for competency on how to obtain and evaluate for orthostatic hypotension, the DSD stated the facility did not assess the competency of their licensed nurses for the orthostatic hypotension. On 7/1/25 at 1419 hours, an interview was conducted with the Assistant Administrator and the DON. The Assistant Administrator and DON were informed and acknowledged the above findings. The DON verified she did not assess the license nurses for their competency on obtaining or evaluating orthostatic hypotension. The DON stated the nurses were trained on how to take BP; however, not for the orthostatic hypotension. The DON further stated the licensed nurses should be trained on orthostatic hypotension to ensure they were aware of how to properly obtain an orthostatic hypotension and assess the findings. 2.a. On 6/26/25 at 0910 hours, an interview was conducted with LVN 1 about orthostatic hypotension. LVN 1 stated orthostatic hypotension BP were checked weekly in lying, sitting, and standing position or per physician's orders. When asked how much of a drop in SBP and DBP would be considered orthostatic hypotension, LVN 1 stated a drop of 20 mmHg for both SBP and DBP. b. Medical record review for Resident 43 was initiated on 6/24/25. Resident 43 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 43's H&P examination dated 11/1/24, showed Resident 43 had no capacity to understand and make decisions. Review of Resident 43's Order Summary Report for 6/2025 showed the following physician's orders: - dated 10/31/24, to monitor orthostatic B/P while lying weekly everyday shift on Saturdays. - dated 10/31/24, to monitor orthostatic B/P while sitting everyday shift on Saturdays for use. Review of Resident 43's MAR for 6/2025 showed the following: (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/27/25 at 0907 hours, a follow-up interview and concurrent medical record review for Resident 1 was conducted with LPT 2. LPT 2 stated the CNAs were responsible for obtaining the residents' sitting and standing BP readings and documenting the vital signs in the Facility 1 TRC Change of Condition Log. LPT 2 stated the LPTs were responsible for reviewing the log for any abnormal vital signs as per the guidelines on the Facility 1 TRC Change of Condition Log, which showed to recheck if the BP reading was less than 90/60 mmHg or greater than 150/90 mmHg. LPT 2 further stated she also compared the BP readings for the sitting and standing positions and if there was a difference of 20 mmHg for the systolic or 10 mmHg for the diastolic BP, then the BP should be retaken. LPT 2 reviewed Resident 1's medical record and verified the above findings. LPT 2 verified on 6/4/25, she entered Resident 1's BP into the MAR. LPT 2 stated she did not notice Resident 1's standing blood pressure reading on 6/4/25, and stated she should have had the CNA recheck Resident 1's BP. LPT 2 further reviewed the Facility 1 TRC Change of Condition Log for 6/4/25, and verified the difference in Resident 1's systolic and diastolic blood pressure readings. LPT 2 stated the difference was considered a drastic drop in the BP. LPT 2 was asked if the facility provided any training on the orthostatic hypotension, or if she had been evaluated on the orthostatic monitoring during her annual skills evaluation. LPT 2 stated she did not recall. On 7/1/25 at 1342 hours, the DON was informed and acknowledged the above findings.

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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, medical record review, and facility P&P review, the facility failed to provide the pharmaceutical services to ensure the accurate administration of the medications as evidenced by: * The facility's medication error rate was 3.85%. One of two licensed nurses (RN 1) who was observed during the medication administration was found to have an error. RN 1 failed to administer the complete dose of one of Resident 53's medications when significant residual of the medication was observed in the medication cup after RN 1 administered the docusate sodium (stool softener) to Resident 53. This failure had the potential to negatively impact the residents' health outcomes. * The facility failed to ensure the accurate reconciliation and documentation of the controlled medications for one nonsampled resident (Resident 748). This failure posed the risk of diversion of controlled medications and medication administration errors. Findings: 1. On 6/25/25 at 0905 hours, a medication administration observation for Resident 53 was conducted with RN 1. RN 1 prepared and administered Resident 53's medication which included the following: - one tablet of docusate sodium 100 mg. - one tablet of multivitamin with minerals (supplement). RN 1 was observed crushing each medication and then adding the applesauce and mixing. RN 1 then administered the above medications to Resident 53. After administering the medications, one medication cup was observed with significant amount of white- colored medication residue. On 6/25/25 at 0913 hours, an interview and concurrent observation was conducted with RN 1. RN 1 verified the above findings and identified the medication as the docusate sodium medication. RN 1 was asked and stated during the medication administration, if there were crushed medication residue observed in the medication cup, she should add more apple sauce, then mix and administer as much of the medication to the resident. On 6/30/25 at 1536 hours, an interview was conducted with the DON. The DON stated all the medications should be administered as ordered by the physician. The DON stated if medication residue was observed in the medication cup, the licensed nurse should add more apple sauce, mix thoroughly, and administer the complete dose. On 7/1/25 at 1342 hours, the DON was informed and acknowledged the above findings. 2. Review of the facility's P&P titled Controlled Substances revised 11/2024 showed the controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Records of personnel access and usage; b. Medication administration records c. Declining inventory records; and d. Destruction, waste, and return to pharmacy records. The nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile inventory count. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the Director of Nursing Services. Closed medical record review for Resident 748 was initiated on 7/1/25. Resident 748 was admitted to the facility on [DATE]. a. Review of Resident 748's Order Summary Report for the month of 10/2024 showed a physician's order dated 9/30/24, to administer alprazolam (antianxiety, brand name Xanax) 0.25 mg by mouth every four hours as needed for anxiety manifested by restlessness for 14 days. Review of Resident 748's Narcotic and Hypnotic Record for Xanax 0.25 mg showed the medication was removed on 10/2/24 at 1900 hours. However, review of Resident 748's MAR for 10/2024 failed to show documented evidence the Xanax medication was administered on 10/2/24. b. Review of Resident 748's Order Summary Report for the month of 10/2024 showed a physician's order dated 9/12/24, to administer morphine sulfate solution (narcotic medication to relieve pain) 20 mg/ml, to give 0.25 ml by mouth every three hours as needed for severe pain or shortness of breath. Review of Resident 748's Narcotic Medication Record for morphine sulfate solution 20 mg/ml, to take 0.25 ml by mouth every three hours as needed, showed the morphine sulfate medication was removed on 10/21/24 at 0700 hours and on 10/21/24 at 1400 hours. However, review of Resident 748's Medication Administration Record for 10/2024 showed Resident 748 was administered the morphine sulfate medication on 10/21/24 at 1259 hours. On 7/1/25 at 1316 hours, an interview and concurrent closed medical record review for Resident 748 was conducted with the DON. The DON stated the licensed nurse should document the removal of the controlled medication on the Narcotic and Hypnotic Record at the time the medication was removed. The DON stated after administering the medication to the resident, the licensed nurse was expected to document the medication administration in the resident's MAR. The DON reviewed Resident 748 medical records and verified the above findings. The DON verified the morphine sulfate medication was removed on 10/21/24 at 0700 hours and at 1400 hours, however, Resident 748's MAR only showed the documentation Resident 748 was administered the morphine sulfate medication once on 10/21/24 at 1259 hours. The DON stated there was a discrepancy between the times the morphine medications were removed and the documented time it was administered to Resident 748. The DON also verified only one dose of the morphine sulfate medication was documented as administered on the MAR when the record showed two doses were removed. On 7/1/25 at 1342 hours, the DON was informed and acknowledged the above findings.

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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. Based on observation, interview, facility P&P review, and facility document review, the facility failed to provide the necessary pharmacy services to ensure proper storage, labeling, and disposal of medications. * The facility failed to ensure the orally administered medications were kept separate from externally used medications, e.g., suppositories, eye drops. This failure posed the risk for the occurrence of error in the medication administration. * The facility failed to ensure the refrigerator containing insulins, vaccines, and other medications requiring refrigeration was monitored daily to ensure the temperature was within the required range. This failure had the potential for the medication to lose the stability and effectiveness of the medication. * The facility failed to ensure the enteral formula (specialized liquid products that deliver nutrients directly to the gastrointestinal tract administered via tube feeding) and other oral nutritional supplements were stored in the room not exposed to excessive heat and freezing. This failure posed the risk of not providing the optimum product quality, a decrease in the level of vitamin availability and nutrient content not meeting the label claim. Findings: Review of the facility's P&P titled Medication Labeling and Storage date February 2023 showed the facility stores all the medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. Medications are stored in an orderly manner in cabinets, drawers, carts or automatic dispensing systems. Each resident's medications are assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents. Medications requiring refrigeration are stored in a refrigerator located in the medication room at the nurse's station or other secured location. Medications are stored separately from food and are labeled accordingly. Medications for external use, as well as hazardous drugs and biologicals, are clearly marked as such, and are stored separately from other medications. 1. On 6/25/25 at 0820 hours, an observation of the TRC medication room and concurrent interview was conducted with LPT 2 and RN 2. The following was observed inside the hanging cabinet attached to the wall at middle shelf, the following over-the-counter medications/ house supply medications were stored together side by side and on top of all the bottles of oral tablets without a separator: - two boxes of Dulcolax suppositories (medication inserted into the rectum to promote bowel movement) - three bottles of Artificial Tears eyedrops and one Systane eyedrop (eye lubricant drops). LPT 2 and RN 2 verified the above findings, removed the medications and stated they should be stored separately. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/1/25 at 1035 hours, an interview was conducted with the DON. The DON was notified of the above findings and acknowledged the external and internal medications should be stored separately. 2. On 6/25/24 at 0850 hours, an observation of the TRC medication room and concurrent interview was conducted with LPT 2 and RN 2. The following was observed inside the locked refrigerator contained two unopened insulin pens (medication to treat blood sugar elevation in diabetes) and two bottles of PPD tests (Purified Protein Derivative- a screening test for tuberculosis). There was a daily monitoring sheet for the refrigerator temperature, with the actual temperature of 40 degrees F during the time of obervation (required temperature range is 36- 46 degrees F). However, further review of the daily temperature monitoring sheet showed no documented temperatures were taken on 5/1 and 5/2/25. LPT 2 and RN 2 verified the above findings. On 7/1/25 at 1038 hours, an interview was conducted with the DON. The DON was notified of the above findings and acknowledged the temperature inside the refrigerator should be monitored and documented daily. 3. On 6/25/25 at 1050 hours, an observation of Skilled Nursing Facility (SNF) Unit utility room and concurrent interview was conducted with the LVN 1. The following was observed inside the utility room: - more than ten bags of Jevity 1.5 enteral formula (brand of formula containing 1.5 calorie of therapeutic nutrition), - ten bags of Diabetisource AC enteral formula (formula for nutritional management of patients with diabetes), - ten bottles of Boost Glucose Control oral supplement in tetra pack (type of food packaging often referred to as a carton or package, - five bottles of Boost Balance supplements. In addition, it was observed there was no monitoring of the room temperature inside the utility room. LVN 1 verified the above findings. On 6/25/25 at 1207 hours, LVN 1 contacted the provider of the nutritional formula, Nestle Health Science, for guidance on the temperature requirement for the nutritional formula. An email was received from the facility's provider of the nutritional formula which showed to provide optimum product quality, Nestle HealthCare Nutrition shelf stable enteral products are to be stored unopened at the room temperature (59 degrees F- 86 degrees F). Exposure to excessive heat and freezing are to be avoided. As with any nutritional product exposed to heat extremes (greater than 104 degrees F for more than 24 hours), decreased in the level of vitamin availability, nutrient content not meeting the label claim, and darkening of the product. Steps for assessing product/ package quality- bring product to the room temperature. On 6/25/25 at 1220 hours, an interview was conducted with the DON. The DON verified the above findings. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/25 at 1335 hours, another observation and concurrent interview was conducted with LVN 1. LVN 1 checked the room temperature and the temperature was 74 degrees F.

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F 0803 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the menu and recipes were followed when: * The facility failed to ensure the residents on regular diets were served with roasted red potatoes instead of mashed potatoes. The food substitution was not communicated in advance to the residents receiving regular diet. This failure posed the risk for negatively impacting the residents' satisfaction and dietary compliance. Findings: Review of the facility's document titled Order Listing Report showed seven of 52 residents residing in the SNF side of the facility received Regular-textured food prepared in the kitchen. Review of the facility's P&P titled Menus revised 12/2008 showed the menus shall meet the nutritional needs of residents, be prepared in advance and be followed. Deviations from the menus that have already been posted will be noted including the reason for the substitution and or deviation in the kitchen and/or in the record book used solely for recording such changes. Review of the facility's document titled Weekly Menu (undated), the spreadsheet for Wednesday, Week 4, showed the residents on Regular diet, on NCS diet, and on Low Fat/ Low Cholesterol diet were to be served with roasted red potatoes. On 6/25/25 at 1105 hours, during the trayline observation, a random inspection was conducted on the lunch trays in the tray cart ready to be served to the residents. The trays for the residents on regular-textured diets were served with mashed potatoes instead of roasted red potatoes. The DSS and [NAME] 1 verified the above findings. The DSS stated the menu should be followed, and residents on Regular-textured diet should be served with roasted red potatoes.

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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. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen. * The facility failed to ensure proper labeling and dating of food in the walk-refrigerator. * The facility failed to ensure the plate lowerator was clean. * The facility failed to ensure the walk-in freezer was free from ice build-up. * The facility failed to ensure proper backflow prevention under the dishwasher. These failures had the potential to cause foodborne illnesses in a medically vulnerable resident population who consumed food prepared from the kitchen. Findings: Review of the facility's document titled Order Listing Report showed 91 of 98 residents residing in the facility who received food prepared in the kitchen. 1. Review of the facility's P&P titled Labeling and Dating of Foods dated 2023 showed all food items in the storeroom, refrigerator, and freezer need to be labeled and dated. Newly opened food items will need to be closed and labeled with an open date and used by the date that follows the various storage guidelines. On 6/24/25 at 0755 hours, an initial tour of the kitchen and concurrent interview was conducted with [NAME] 1. An opened bag of chicken nuggets was observed not labeled and dated inside the walk-in refrigerator. There was no box to identify the received date, and when the bag of chicken nuggets was opened. [NAME] 1 verified the findings. 2. According to the FDA Food Code 2022, 4-601.11, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the FDA Food Code 2022, 4-602.13, Non-Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. Review of the facility's P&P titled Sanitation dated 2023 showed all utensils, counters, shelves, and equipment shall be kept clean. On 6/24/25 hours at 0755 hours, during the initial tour of the kitchen, charger plates were observed stored inside the heated plate lowerator. The heated plate lowerator was observed with dirt, a fork, and a foil at the lower surface of the lowerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/24/25 hours at 1125 hours, during the trayline observation, charger plates were observed stored inside the heated plate lowerator. The heated plate lowerator was observed with dirt, a fork, and a spoon at the lower surface of the lowerator. The DSS verified the findings. The DSS stated the maintenance department checked the kitchen equipment at the end of every month and the maintenance department had to check and disassemble the heated plate lowerator to clean it. 3. On 6/24/25 at 0755 hours, during the initial tour of the kitchen, the walk-in freezer was observed with a thick ice build-up on the plastic lining on the interior part of the freezer near the door. [NAME] 1 verified the above findings 4. According to the FDA Food Code 2022, 5-202.13, Backflow Prevention, Air Gap, an air gap between the water supply inlet and flood level rim of the plumbing fixture, equipment, or nonfood equipment shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm. Review of the facility's P&P titled Accident Prevention - Safety Precautions dated 2023, under Backflow Prevention/ Air Gaps section showed the following: - An airgap is the most reliable backflow prevention device. It is the physical separation of the potable and non-potable water supply systems by air space. All steam tables, ice machines and bins, food preparation sinks, display cases, soda fountains, espresso machines, and other equipment that discharge liquid waste or condensate shall be drained through an air gap into an open floor sink; and - An airgap between the water supply inlet (drainpipe) and the flood level rim of the plumbing fixture (floor sink drain), equipment or non-food equipment shall be at least twice the diameter of the water supply inlet and may not be less than one inch. On 6/24/25 at 0755 hours, during the initial tour of the kitchen, the metal drainpipe under the dishwasher was observed below the flood level rim and into the drainage inlet. On 6/25/25 at 1145 hours, the metal drainpipe under the dishwasher was observed below the flood level rim and into the drainage inlet. The DSS verified the above findings. On 6/25/25 at 1155 hours, the Maintenance/ Housekeeping Director verified the above findings.

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Extended Care Hospital of Westminster	206 Hospital Circle Westminster, CA 92683

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, and facility P&P review, the facility failed to follow the facility's P&P regarding the use and storage of food brought to the residents by the family or visitors. In addition, the facility failed to ensure the staff were aware of the facility's P&P on safe food handling of outside food. These failures had the potential to cause foodborne illnesses to the medically vulnerable resident population who consume food brought from outside sources. Findings: Review of the CMS S&C-09-39 Food Procurement, and Self-Determination and Participation dated 5/29/09, showed the following: - The residents have the right to choose to accept food from visitors, family, friends, or other guests according to their rights to make choices; and - The facility has the responsibility under the food safety regulation to help visitors to understand safe food handling practices such as not holding or transporting foods containing perishable ingredients at temperatures above 41 degrees F. Review of the facility's P&P titled Foods Brought by Family/ Visitors revised 3/2022 showed the following: - Food brought by family/ visitors left with the resident to consume later is labeled and stored in a manner that is clearly distinguishable from facility-prepared food; - Non-perishable foods are stored in a resealable containers with tight-fitting lids. Intact fresh fruit may be stored without a lid; - Perishable foods are stored in a resealable containers with tight-fitting lids in a refrigerator. Containers are labeled with the resident's name, the item and the use by date; and - The nursing staff will discard perishable foods on or before the use by date. Review of the facility's P&P titled Food for Residents From Outside Sources dated 2023 showed the following: - Non-perishable foods such as cookies, cake, crackers, fruit, etc. (do not require time and temperature holding), can be stored in the resident's room or at the nurses' station with the resident's name and date of storage. If unopened, refer to the Dry Food Storage Guide. If opened, the food must be sealed, dated to the date opened and disposed by the best by date or 30 days, whichever comes first; and (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Prepared foods, beverages, or perishable food that require refrigeration, can be stored for the resident in the facility kitchen, the refrigerator within the nurses' station, or in the resident's personal refrigerator. In the Food and Nutrition Services Department, the policy on food storage will apply. Otherwise, if unopened, refrigerated or frozen items will be disposed of by expiration date on the container. If opened, the food must be sealed, dated to the date opened and disposed of in two days after opening. Frozen items, such as ice cream, will be disposed of in 30 days. On 6/24/25 at 0755 hours, during the initial tour of the kitchen, and concurrent interview with [NAME] 1. [NAME] 1 was asked how the facility staff stored food brought in from outside the facility. [NAME] 1 stated the food brought in from outside the facility was stored outside the kitchen, and the nursing staff was responsible for it. On 6/24/25 at 0941 hours, an interview was conducted with LVN 1. When asked how the facility staff stored food brought in from outside the facility, LVN 1 stated when the visitors brought the food items for the resident and there was a left-over food during lunch time, the nursing staff were to label the food items with the resident's name and date when it was received, and to store the food items inside the employee refrigerator. LVN 1 further stated the left-over food items were not kept inside the employee refrigerator for a long time, and the left-over food items were given or fed to the resident during dinner time. LVN 1 was asked to show the employee refrigerator. The employee refrigerator was in the facility patio, observed with several food items and lunch bags, with a temperature of 40 degrees F, and rust was observed on the outer panel of the freezer door. LVN 1 stated they do not have any resident food items inside the employee refrigerator at this time. When asked how the employee refrigerator was monitored, LVN 1 stated the employee refrigerator was not monitored for temperature and sanitation. On 6/25/25 at 1126 hours, an interview was conducted with the DSS. When asked how the facility staff stored food brought in from outside the facility, the DSS stated the food items brought in from outside the facility were labeled with the resident's name, room number, the date when the food items were brought in, and the use by date, placed in a separate container and stored inside the walk-in refrigerator in the kitchen. The DSS stated the container was clearly labeled for the food items brought in from outside the facility and placed separately from the food items inside the walk-in refrigerator. On 6/26/25 at 1103 hours, an interview was conducted with RN 1. When asked how the facility staff stored food brought in from outside the facility, RN 1 stated we have a refrigerator outside, but that was for the employees. RN 1 further stated she was not sure because she has not had any food brought in from outside the facility for the residents. When asked if she was provided a training on safe handling and storage of food from outside sources, RN 1 stated she was not trained but her orientation included to educate the residents and their families adhering to the residents' diet while in the facility. On 6/26/25 at 1430 hours, an interview was conducted with the DON and DSS. When asked for any inservices or training provided to the staff regarding food brought in from outside the facility, the DON and DSS were not able to provide any documentation the facility provided education to the facility staff.

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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, medical record review, and facility P&P review, the facility failed to implement the infection control practices designed to provide a safe and sanitary environment; and prevent the transmission of diseases and infections for two of 21 final sampled residents (Residents 31 and 45) and six nonsampled residents (Residents 17, 27, 28, 33, 40, and 84). * The facility failed to ensure CNA 1 performed hand hygiene between assisting Residents 31 and 84 with meals. In addition, the facility failed to ensure CNA 1 performed hand hygiene between assisting Residents 31 and 17 with meals. * The facility failed to ensure CNA 2 performed hand hygiene between assisting Residents 27 and 28 with meals. * The facility failed to ensure CNA 3 performed hand hygiene between assisting Residents 33 and 45 with meals. * The facility failed to ensure LVN 2 performed hand hygiene before administering a nebulizer treatment for Resident 40. These failures posed the risk for transmission of disease-causing microorganisms. Findings: 1. Review of the facility's P&P titled Handwashing/ Hand Hygiene revised 8/2019 showed all personnel shall follow the handwashing/ hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-microbial) and water for the following situations: - Before and after direct contact with residents; and - Before and after assisting a resident with meals On 6/24/25 at 1230 hours, during the initial dining observation, inside the dining room, CNA 1 was observed seated in between Residents 31 and 84. CNA 1 was observed feeding Residents 31 and 84 at the same time. In addition, CNA 1 was observed touching the residents' bibs during the feeding. CNA 1 was not observed performing hand hygiene between assisting Residents 31 and 84 with meals. On 6/24/25 at 1242 hours, another CNA took over to assist Resident 31 with feeding. CNA 1 assisted Resident 84 with feeding. Then, CNA 1 was observed taking Resident 84 out of the dining room, when Resident 84 was done eating. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/24/25 at 1245 hours, CNA 1 was observed taking Resident 17 in the dining room. CNA 1 was observed taking Resident 17's tray from the cart, and placed the lunch tray on the table, where Resident 31 was seated. CNA 1 sat in between Residents 17 and 31. At this time, the other CNA assisting Resident 31 left. CNA 1 was observed to continue assisting Resident 31 with meals and assisted Resident 17 with meals at the same time. CNA 1 was observed touching the residents' bibs during the feeding. CNA 1 was not observed performing hand hygiene between assisting Residents 31 and 17 with meals. On 6/24/25 at 1452 hours, an interview was conducted with CNA 1. CNA 1 verified she assisted Residents 31 and 84 with meals at the same time and assisted Residents 31 and 17 with meals at the same time. CNA 1 verified she did not perform hand hygiene between assisting Residents 31 and 17 with meals. Cross reference to F550, example #1. 2. On 6/24/25 at 1235 hours, during the initial dining observation, inside the dining room, CNA 2 was observed seated between Residents 27 and 28. CNA 2 was observed feeding Residents 27 and 28 at the same time. CNA 2 was observed touching the residents' bibs during the feeding. CNA 2 was not observed performing hand hygiene between assisting Residents 27 and 28 with meals. On 6/24/25 at 1444 hours, an interview was conducted with CNA 2. CNA 2 verified she assisted Residents 27 and 28 with meals at the same time. CNA 2 verified she did not perform hand hygiene between assisting Residents 27 and 28 with meals. Cross reference to F550, example #2. 3. On 6/24/25 at 1239 hours, during the initial dining observation, inside the dining room, CNA 3 was observed seated in between Residents 33 and 45. CNA 3 was observed feeding Residents 33 and 45 at the same time. CNA 3 was observed touching the residents' bibs during the feeding. CNA 3 was not observed performing hand hygiene between assisting Residents 33 and 45 with meals. On 6/24/25 at 1456 hours, an interview was conducted with CNA 3. CNA 3 verified he assisted Residents 33 and 45 with feeding at the same time. CNA 3 verified he did not perform hand hygiene between assisting Residents 33 and 45 with meals. On 6/26/25 at 1116 hours, an interview was conducted with the DSD and LVN 1. The DSD stated the CNAs were trained to assist the residents with feeding, and to perform hand hygiene when providing assistance with meals to the residents. The DSD stated the CNAs were supposed to perform hand hygiene before and after assisting a resident with meals. Cross reference to F550, example #3. 4. Review of the facility's P&P titled Handwashing/Hand Hygiene revised 08/2019 showed to use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap and water for the following situations: - before and after direct contact with residents; - before preparing and handling medications; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- after contact with objects in the immediate vicinity of the resident. Review of the facility's P&P titled Administering Medications through a Small Volume (Handheld) Nebulizer (a small machine which turns liquid medication into a mist for inhalation delivered by a connected facemask or mouthpiece), revised 10/2010 showed the purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway. The steps in the procedure showed to: 1. Assemble equipment and supplies on the resident's overbed table. 2. Wash and dry hands. 3. Provide for the resident's privacy. 4. Explain the procedure to the resident. 5. Position the resident in semi-Fowler's (body positioning technique where a patient lies on their back with the head of the bed elevated between 30 and 45 degrees) position. 6. Obtain baseline pulse, respiratory rate, and lung sounds. 7. Wash and dry hands. 8. Draw up the medication to be nebulized. Medical record review for Resident 40 was initiated on 6/25/25. Resident 40 was admitted to the facility on [DATE]. On 6/25/25 at 0928 hours, a medication administration observation was conducted with LVN 2 for Resident 40. LVN 2 was observed preparing the following medications: - one tablet of amiodarone (antiarrhythmic) 200 mg, - one tablet of Eliquis (anticoagulant) 5 mg, - one tablet of Folic Acid (supplement) 1 mg, - one tablet of hydralazine (antihypertensive) 50 mg, - one tablet of loratadine (antihistamine) 10 mg, - one tablet of multivitamin with mineral (supplement) - 30 ml of Prostat (liquid protein), - one tablet of vitamin B1 100 mg, - one tablet of vitamin C 500 mg, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- two tablets of vitamin D 25 mcg, and - one vial of budesonide (corticosteroid, to treat conditions like asthma) 0.5 mg/2 ml. LVN 2 was observed performing hand hygiene and administering Resident 40's oral medications. After administering Resident 40's oral medications, LVN 2 was observed using Resident 40's bed control to raise Resident 40's head of the bed. LVN 2 was then observed opening the vial of the budesonide medication and squeezing the solution into Resident 40's nebulizer cup. LVN 2 was observed removing the nebulizer mask and tubing from the plastic storage bag, connecting the tubing to the nebulizer machine, and placing the nebulizer mask on Resident 40. LVN 2 was not observed performing hand hygiene. On 6/25/25 at 0956 hours, an interview was conducted with LVN 2. LVN 2 stated when administering the medications via different routes to the residents, the facility's protocol was to perform hand hygiene between each medication administration route. LVN 2 stated after the administration of oral medications and before the preparation and administration of a breathing treatment, hand hygiene should be performed for infection control purposes. LVN 2 verified she did not perform hand hygiene after the administration of oral medications and prior to the preparation and administration of the breathing treatment to Resident 40. On 6/30/25 at 1536 hours, an interview was conducted with the DON. The DON stated the licensed nurses were expected to perform hand hygiene after the administration of oral medications and before the preparation of the breathing treatment, for infection control purposes and to prevent any cross contamination. On 7/1/25 at 1342 hours, the DON was informed and acknowledged the above findings.