STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555217	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacifica Hospital of the Valley Dp Snf	9449 San Fernando Road Sun Valley, CA 91352

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 47883 Based on observation, interview, and record review the facility failed to keep the call light (an alerting device for nurses or other nursing personnel to assist a patient when in need) within reach of the resident for one out of one sampled resident (Resident 11). This deficient practice had the potential to result in the resident not being able to call for facility staff assistance and delay in the provision of necessary care and services that can negatively affect resident's comfort and well-being Findings: During a review of Resident 11's Inpatient Registration Form, the Inpatient Registration Form indicated the facility admitted Resident 11 on 5/4/2015 and readmitted Resident 11 on 5/9/2017. During a review of Resident 11's History and Physical (H&P), dated 7/1/2024, the H&P indicated Resident 11 was admitted with diagnosis included Guillain-Barre (GBS- a rare autoimmune disease that occurs when the body's immune system attacks the peripheral nervous system), diabetes mellitus type 2 (a long-term medical condition in which the body does not use insulin [a hormone that lowers the level of sugar in the blood] properly), and hypertension(a condition in which blood pressure is higher than normal) . The H&P indicated Resident 11 had the capacity to understand and make decisions. During a review of Resident 11's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 11/11/2024, the MDS indicated the Resident 11 had intact cognition (undamaged mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS further indicated that Resident 11 was totally dependent on staff or required maximal assistance with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 11's self-care deficit care plan initiated on 01/28/2024, the care plan indicated an intervention to place the call light within easy reach of resident's bedside. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 10/27/2024, at 12:45 p.m., in Resident 11's room, observed the resident in bed, covered with blanked with the adaptive call light (a specially designed call button or call light system that can be used by individuals with physical disabilities or limited mobility to easily signal for assistance) on the left side of Resident 11' s head of the bed. The resident stated that he is able to move only his head, and he could not reach the adaptive call light because it is not close to his head. During an interview on 1/27/2025 at 12:46 p.m., with Registered Nurse 3 (RN 3), RN 3 confirmed that the adaptive call light was not within reach of Resident 11. RN 3 stated the call light should have been close enough that Resident 11 can use it by turning his head. RN 3 stated the deficient practice had the potential for the resident not able to ask for help when needed and could result in the resident falling. During an interview on 1/28/2025 at 4:13 p.m. with the Director of Staff Development (DSD), the DSD stated that when making rounds, staff should ensure the residents' call light should always be reachable by clipping the call light on the pillow. The DSD stated that when the call light is not within reach of the resident, the resident may be unable to ask for assistance and could risk falling when attempting to reach for the call light. During a review of the facility's recent policy and procedure (P&P) titled Call System last reviewed on 1/2025, the P&P indicated: It is the policy of this facility to provide each resident with call system to enable them to request assistance .Make sure call cords are placed within the resident's reach at all times.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on interview, and record review, the facility failed to follow the facility`s policy and procedure titled Advanced Directives, for two of five sampled resident (Resident 46 and Resident 35) by failing to: 1. Ensure that Resident 46 was provided written information concerning the right to refuse or accept medical or surgical treatments and formulate an Advanced Directive (AD-a written instruction, recognized under State law, relating to the provision of health care when the individual is unable to make decisions for themself) upon admission. 2. Maintain a current copy of Resident 35`s advance directives in the resident's clinical record. These deficient practices had the potential for the facility to not honor the resident's medical decisions regarding end-of-life treatment and had the potential to cause conflict with Resident 35 and 46's wishes regarding health care. Findings: 1. During a review of Resident 46's History and Physical (H&P) dated 9/19/2024, the H&P indicated that the facility admitted the resident on 9/19/2024, with diagnoses including stroke (a loss of blood flow to part of the brain, which damages brain tissue), tracheostomy (an opening surgically created through the neck into the windpipe to allow air to fill the lungs), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and seizure disorder (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a review of Resident 46's Minimum Data Set (MDS - a resident assessment tool) dated 12/20/2024, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was intact (decisions consistent/reasonable). The MDS indicated that Resident 46 was dependent to staff (helper does all of the effort) for oral hygiene, toileting hygiene, upper and lower body dressing, putting on/talking off footwear, and personal hygiene. During a concurrent interview and record review on 1/29/2025 at 11:07 a.m., with Registered Nurse 1 (RN1), Resident 46's medical chart was reviewed. RN 1 stated that the social service department is in charge of completing Advance Directive Acknowledgment forms (ADA-a document provided by the facility that indicates whether a resident has an Advance Directive, would like information regarding creation of an advance directive, or refusal to create an advance directive) for residents upon their admission to the facility. RN 1 stated that the ADA form for Resident 46 was not completed upon her admission to the facility on [DATE]. RN 1 stated that if no information is provided to the resident regarding AD, then it is a violation of their right to be informed of the option to formulate an AD. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/29/2025 at 1:30 p.m., with Social Worker 1 (SW 1), Resident 46`s medical records were reviewed. SW 1 stated that the ADA form should be completed upon admission. SW1 stated that the ADA form contains information regarding the resident`s right to be informed and to receive information on how to formulate an AD. SW 1 stated that she (SW1) did not complete an ADA form for Resident 46 upon her admission to the facility on [DATE]. SW1 stated if the resident was not provided information regarding AD, there is a risk that the resident's wishes may not be honored. During a review of the facility's Policy and Procedure (P&P) titled, Advance Directives, last reviewed on 7/2024, the P&P indicated that upon admission the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and formulate an advanced directive if he or she chooses to do so. Information about whether or not the resident has executed an AD shall be displayed prominently in the medical record. If the resident indicates that he or she has not established an AD, the facility staff will offer assistance in establishing an AD. 47883 2. During a review of Resident 35's Inpatient Information Form, the Inpatient Information Form indicated that the facility admitted Resident 35 on 11/20/2024 and readmitted the resident on 12/3/2024. During a review of Resident 35's History and Physical (H&P), dated 7/10/2024, the H&P indicated the facility admitted the resident with diagnoses including chronic respiratory failure (a condition in which the lungs are unable to adequately exchange oxygen [odorless and tasteless gas that is essential for life] and carbon dioxide [a colorless, odorless gas that's naturally produced when we breath] over a prolong time), type 2 diabetes (a long-term medical condition in which the body does not use insulin [a hormone that lowers the level of sugar in the blood] properly), and chronic encephalopathy (the group of condition that cause brain dysfunction[can appear as confusion, memory loss and personality change). During a review of Resident 35's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 6/3/2024, the MDS indicated that the resident had severely impaired cognition (severely damaged mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS further indicated that Resident 35 was totally dependent on staff or required maximal assistance with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a concurrent interview and record review with Social Worker 1 (SW 1), on 1/28/2025 at 9:43 a.m., Resident 35's clinical records including the Advance Directive acknowledgement form were reviewed. SW1 stated that the resident's Advance Directive acknowledgement form indicated that Resident 35 had an advance directive. SW1 stated that the advance directive was not in the chart. SW1 stated that a copy of Resident 35's advance directive should have been kept in the resident's chart to provide guidance to the facility staff about the resident's wishes. During an interview with the Director of Staff Development (DSD) on 1/28/2025 at 4:13 p.m., the DSD stated that a copy of Resident 35's advance directive should have been kept in the resident's chart to ensure the resident's wishes would be carried out, and to provide guidance to the facility staff about the resident's wishes. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policies and procedures titled Advance Directives, revised 7/2024, indicated that it is the policy of the facility to comply with state law regarding the development and implementation of a resident's advance directives. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 44309 Based on interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a plan of care that summarizes a resident's health conditions, specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition, and current treatments) to meet the resident`s needs for three of three sampled residents (Resident 46, Resident 55 and Resident 57) by failing to:  1. Develop and implement a comprehensive person-centered care plan addressing Resident 46`s Restorative Nursing Assistant program (RNA-nursing aide program that helps residents to maintain their function and joint mobility). This deficient practice had the potential to result in Resident 46`s inadequate care.  2. Develop and implement a comprehensive person-centered care plan addressing Resident 57 and 55`s antibiotic (drugs that kill bacteria) therapy. This deficient practice had the potential to result in failure to deliver the necessary care and services. Findings: 1. During a review of Resident 46's History and Physical (H&P) dated 9/19/2024, the H&P indicated that the facility admitted the resident on 9/19/2024, with diagnoses including stroke (a loss of blood flow to part of the brain, which damages brain tissue), tracheostomy (an opening surgically created through the neck into the windpipe to allow air to fill the lungs), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and seizure disorder (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a review of Resident 46's Minimum Data Set (MDS - a resident assessment tool) dated 12/20/2024, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was intact (decisions consistent/reasonable). The MDS indicated that Resident 46 was dependent to staff (helper does all of the effort) for oral hygiene, toileting hygiene, upper and lower body dressing, putting on/talking off footwear, and personal hygiene. During a review of Resident 46`s Medication Review Report (physician order) dated 12/26/2024, the report indicated an order for Restorative Nursing Assistant program (RNA-nursing aide program that helps residents to maintain their function and joint mobility) to provide Passive Range of Motion (PROM-when an outside force such as a therapist exclusively causes movement of a joint) and Active Assistive Range of Motion (AAROM-use of muscles surrounding the joint to perform the exercise but requires some help from the therapist or equipment) to Resident 46`s Bilateral Upper Extremities (BUE-both arms) and Bilateral Lower Extremities (BLE-both legs) five times a week for 90 days. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/30/2025 at 9:37 a.m., with Registered Nurse 2 (RN 2), Resident 46`s physician orders and care plans were reviewed. RN 2 stated Resident 46`s physician ordered for an RNA program five times a week for 90 days on 12/26/2024. However, licensed staff did not develop a comprehensive care plan with person-centered interventions for the resident`s RNA program. RN 2 stated Resident 46 had a stroke and has left sided weakness and a care plan with person-centered intervention is required to monitor the resident's range of motion (ROM- full movement potential of a joint) improvement. RN 2 stated the potential outcome of not developing a person-centered care plan with goals and interventions for a resident who has weakness due to stoke is a lack of care and the inability to implement the specific services and monitoring that the resident requires. During a review of the facility's policy and procedure (P&P) titled, Care Planning, last revised on 7/2024, the P&P indicated that the purpose of this policy is to assure a coordinated and comprehensive written plan is developed based on the resident assessment instrument and on the individual needs of the resident. It is the policy of this facility that within 24 hours of admission, a coordinated and comprehensive written plan is developed based on the resident assessment instrument and on the individual needs of the resident. Resident care planning includes participation from all involved health care disciplines at resident care conferences with continual reassessment, and updating at least quarterly, and upon change of condition, until resident's discharge. The long-term goal is stated in relation to the expected outcome of the resident's condition and is determined collectively by the health care team as part of the review of the care plan. Reviews will be recorded by date in number sequence. Objectives/goals are expectations, within the resident's abilities, which can be reached realistically. Each problem should have an objective/goal that is simple, specific and measurable within a specified time frame. 38469 2.a. During a review of Resident 57's Patient Information, the Patient Information indicated that the facility admitted the resident on 1/13/2025. During a review of Resident 57`s History and Physical (H&P- the most formal and complete assessment of the patient and the problem) dated 1/22/2025, the H&P indicated that the resident had multiple diagnoses including chronic renal failure (involves a gradual loss of kidney function) and type 2 diabetes mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel). During a review of Resident 57's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 11/27/2024, the MDS indicated Resident 57`s cognitive (ability to think, understand and reason) skills for daily decision making was severely impaired and was dependent on staff for activities of daily living (ADLs - activities related to personal care). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 1/29/25 at 8:40 a.m., with Registered Nurse 1 (RN 1) reviewed Resident 57`s physician`s order dated 1/21/2025 for Zosyn (used to treat infections caused by bacteria) 3. 375 milligram (mg) intravenously (refers to giving medicines or fluids through a needle or tube inserted into a vein) every 8 hours for pneumonia (an infection that inflames the air sacs in one or both lung). RN 1 stated that Resident 57 had pneumonia which was a change in the resident's condition and an antibiotic (Zosyn) was prescribed on 1/21/2025. RN 1 stated any changes in the resident's condition including antibiotic treatment, would require the development of a short-term care plan. RN 1 stated a care plan for antibiotic therapy would include monitoring for any adverse reactions to the antibiotic such as rashes, nausea and vomiting and swelling of the eyes. RN 1 stated that with a care plan in place, the nurses would be able to identify if the resident is having an adverse reaction to the antibiotic and will be able to intervene timely and evaluate if the treatment is effective or not. RN 1 stated that a care plan also serves as communication tool among nurses to ensure continuity of care. RN 1 stated that Resident 57 could have had an adverse reaction from the antibiotic (Zosyn) such as nausea and vomiting which could lead to dehydration. During a review of the facility`s policy and procedure, titled Care Planning, last reviewed on 7/2024, the policy indicated that a purpose To assure a coordinated and comprehensive written plan is developed based on the resident assessment instrument and on the individual needs of the resident .  During a review of the facility`s policy and procedure, titled Change in Resident Condition, last reviewed on 7/2024, the policy indicated that All signs and symptoms of the condition change will be communicated to the physician promptly .document resident change of condition and response in Nursing Progress Notes, on a 24-hour report and update resident care plan as indicated . 2.b. During a review of Resident 55's Patient Information, the Patient Information indicated that the facility admitted the resident on 8/22/2024. During a review of Resident 55`s History and Physical (H&P- the most formal and complete assessment of the patient and the problem) dated 10/28/2024, the H&P indicated that the resident had multiple diagnoses including dysphagia (difficulty swallowing) and hypertension (a condition in which the force of the blood against the artery walls is too high). During a review of Resident 55's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 11/29/2024, the MDS indicated Resident 55 is in a persistent vegetative state (comatose). The MDS indicated that Resident was totally dependent on staff for activities of daily living (ADLs - activities related to personal care). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 1/29/25 at 9:13 a.m., with Registered Nurse 1 (RN1) reviewed Resident 55`s physician`s order dated 10/27/2024 for Zosyn (used to treat infections caused by bacteria) 3. 375 milligram (mg) intravenously (refers to giving medicines or fluids through a needle or tube inserted into a vein) every 8 hours for urosepsis (a serious infection that occurs when a urinary tract infection [UTI] spreads to the kidneys). RN 1 stated that Resident 55 had a urosepsis which was a change in the resident's condition and an antibiotic was prescribed (Zosyn) on 10/27/2024. RN 1 stated any changes in the resident's condition including antibiotic treatment, would require the development of a short-term care plan. RN 1 stated a care plan for antibiotic therapy would include monitoring for any adverse reactions to the antibiotic such as rashes, nausea and vomiting and swelling of the eyes. RN 1 stated that with a care plan in place, the nurses would be able to identify if the resident is having an adverse reaction to the antibiotic and will be able to intervene timely and evaluate if the treatment is effective or not. RN1 stated that a care plan also serves a communication tool among nurses to ensure continuity of care. RN 1 stated that Resident 55 could have had an adverse reaction from the antibiotic (Zosyn) such as nausea and vomiting which could lead to dehydration. During a review of the facility`s policy and procedure, titled Care Planning, last reviewed on 7/2024, the policy indicated that a purpose To assure a coordinated and comprehensive written plan is developed based on the resident assessment instrument and on the individual needs of the resident .  During a review of the facility`s policy and procedure, titled Change in Resident Condition, last reviewed on 7/2024, the policy indicated that All signs and symptoms of the condition change will be communicated to the physician promptly .document resident change of condition and response in Nursing Progress Notes, on a 24-hour report and update resident care plan as indicated .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 38469 Based on interview and record review, the facility failed to: 1. Ensure the Interdisciplinary Team (IDT-a group of experts from various disciplines working together to treat your ailment, injury, or chronic health condition) invite the resident and /or the resident's representative to participate in the IDT Care Conferences for three out of five (R6, 48 and 55) sampled residents. As a result, the resident and their resident representative were unable to participate in developing the care plan or making decisions about his or her care. 2. Update and revise a resident's care plan (a document outlining a detailed approach to care customized to an individual resident's need) after the resident`s indwelling catheter (a hollow tube inserted into the bladder to drain or collect urine) was removed on 1/7/2025, for one of three (Resident 38) sampled residents reviewed under urinary catheter/ Urinary Tract Infection (UTI- an infection in the bladder/urinary tract) care area. This deficient practice had the potential to result in Resident 38 receiving inadequate care. Findings: 1.a. During a review of Resident 6's Patient Information, the Patient Information indicated that the facility admitted the resident on 12/29/2020. During a review of Resident 6`s History and Physical (H&P- the most formal and complete assessment of the patient and the problem) dated 9/06/2024, the H&P indicated that the resident had multiple diagnoses including chronic traumatic encephalopathy (a brain disorder likely caused by repeated head injuries) and seizure disorder (abnormal electrical activity in your brain). During a review of Resident 6's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 1/09/2025, the MDS indicated Resident 6 is in a persistent vegetative state (comatose). The MDS indicated that Resident 6 was totally dependent on staff for self-care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review and interview on 1/30/2025 at 8:11 a.m., with Social Worker 1 (SW 1), reviewed the monthly IDT for Resident 6. SW 1 stated that they conduct monthly and quarterly IDTs. SW 1 stated that during the IDT meetings the team will discuss the resident's plan of care, any changes in the resident`s condition and the objective of the IDT is to come up with a resident-centered care plan. SW 1 stated that it is important to have the resident or the resident's representative to be invited in the IDT meeting to get their input, such as food and activity preferences to ensure the care plan is resident centered. SW 1 stated that it has been a long time since she has read the policy on IDT and from what she can remember the policy states that the resident's family or representative should be involved in the meeting. SW1 stated if the resident's representative does not attend the IDT meeting, the care plan developed may not be resident-centered or able to address the resident's needs. SW1 stated the IDT meeting was held on the following dates and no invitation was extended to Resident 6's representative: 1.01/08/2025 2.11/06/2024 3. 9/04/2024 4. 8/07/2024 During a review of the facility`s policy and procedure, titled Interdisciplinary Team, last reviewed on 7/2024, the policy indicated that Each resident will have an Interdisciplinary Team Conference Meeting held monthly for the Sub-Acute program and weekly for the Transitional Care Program .The Interdisciplinary Team is composed of the Physician, Clinical Manager, MDS Coordinator, Charge Nurse and/or Licensed Nurse who provide care for the resident, a representative from Social Services, Activities, Dietary, Physical, Occupational and Speech Therapies, Respiratory Therapy, Pharmacy, Nursing Assistants, Case Manager(s), Chaplin. The participation of the resident, the resident`s family or resident`s representative is encouraged and welcomed whenever possible . 1.b. During a review of Resident 48's Patient Information, the Patient Information indicated that the facility admitted the resident on 2/16/2024. During a review of Resident 48`s History and Physical (H&P- the most formal and complete assessment of the patient and the problem) dated 2/19/2024, the H&P indicated that the resident had multiple diagnoses including dysphagia (difficulty swallowing) and multiple fractures. During a review of Resident 48's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 11/21/2024, the MDS indicated Resident 48 is in a persistent vegetative state (comatose). The MDS indicated that Resident 48 was totally dependent on staff for self-care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/30/2025 at 8:11 a.m., with Social Worker 1 (SW1), reviewed Resident 48's monthly IDT meetings. SW 1 stated that during the IDT meetings the team will discuss the resident's plan of care, any changes in the resident`s condition and the objective of the IDT is to come up with a resident-centered care plan. SW 1 stated that it is important to have the resident`s or the resident's representative to be invited in the IDT meeting to get their input, such as food and activity preferences to ensure the care plan is resident centered. SW 1 stated that it has been a long time since she has read the policy on IDT and from what she can remember the policy states that the resident's family or representative should be involved in the meeting. SW1 stated if the resident's representative does not attend the IDT meeting, the care plan developed may not be resident-centered or able to address the resident's needs. SW1 stated the IDT meeting was held on the following dates and no invitation was extended to Resident 48's representative: 1.01/27/2025 2.10/28/2024 3.08/26/2024 During a review of the facility`s policy and procedure, titled Interdisciplinary Team, last reviewed on 7/2024, the policy indicated that Each resident will have an Interdisciplinary Team Conference Meeting held monthly for the Sub-Acute program and weekly for the Transitional Care Program .The Interdisciplinary Team is composed of the Physician, Clinical Manager, MDS Coordinator, Charge Nurse and/or Licensed Nurse who provide care for the resident, a representative from Social Services, Activities, Dietary, Physical, Occupational and Speech Therapies, Respiratory Therapy, Pharmacy, Nursing Assistants, Case Manager(s), Chaplin. The participation of the resident, the resident`s family or resident`s representative is encouraged and welcomed whenever possible . 1.c. During a review of Resident 55's Patient Information (IP), the Patient Information indicated that the facility admitted the resident on 8/22/2024. During a review of Resident 55`s History and Physical (H&P- the most formal and complete assessment of the patient and the problem) dated 10/28/2024, the H&P indicated that the resident had multiple diagnoses including dysphagia (difficulty swallowing) and hypertension (a condition in which the force of the blood against the artery walls is too high). During a review of Resident 55's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 11/29/2024, the MDS indicated Resident 55 is in a persistent vegetative state (comatose). The MDS indicated that Resident was totally dependent on staff for self-care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/30/2025 at 8:11 a.m., with Social Worker 1 (SW1), reviewed Resident 55's monthly IDT meetings. SW 1 stated that during the IDT meetings the team will discuss the resident's plan of care, any changes in the resident`s condition and the objective of the IDT is to come up with a resident-centered care plan. SW 1 stated that it is important to have the resident`s or the resident's representative to be invited in the IDT meeting to get their input, such as food and activity preferences to ensure the care plan is resident centered. SW 1 stated that it has been a long time since she has read the policy on IDT and from what she can remember the policy states that the resident's family or representative should be involved in the meeting. SW1 stated if the resident's representative does not attend the IDT meeting, the care plan developed may not be resident-centered or able to address the resident's needs. SW1 stated the IDT meeting was held on the following dates and no invitation was extended to Resident 55's representative: 1. 01/27/2025 2. 10/28/2024 3. 08/26/2024 During a review of the facility`s policy and procedure, titled Interdisciplinary Team, last reviewed on 7/2024, the policy indicated that Each resident will have an Interdisciplinary Team Conference Meeting held monthly for the Sub-Acute program and weekly for the Transitional Care Program .The Interdisciplinary Team is composed of the Physician, Clinical Manager, MDS Coordinator, Charge Nurse and/or Licensed Nurse who provide care for the resident, a representative from Social Services, Activities, Dietary, Physical, Occupational and Speech Therapies, Respiratory Therapy, Pharmacy, Nursing Assistants, Case Manager(s), Chaplin. The participation of the resident, the resident`s family or resident`s representative is encouraged and welcomed whenever possible . 44309 2. During a review of Resident 38's History and Physical (H&P) dated 6/25/2024, the H&P indicated that the facility admitted the resident on 5/23/2022, with diagnoses including hemorrhagic stroke (a life-threatening emergency that happens when a blood vessel in your brain breaks and bleeds), tracheostomy (an opening surgically created through the neck into the windpipe to allow air to fill the lungs), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and recurrent Urinary Tract Infection (UTI- an infection in the bladder/urinary tract). During a review of Resident 38's Minimum Data Set (MDS - a resident assessment tool) dated 11/26/2024, the MDS indicated that the resident was at persistent vegetative state (a chronic disorder in which an individual with severe brain damage appears to be awake but shows no evidence of awareness of their surroundings). The MDS indicated that Resident 38 was dependent to staff (helper does all of the effort) for oral hygiene, toileting hygiene, showering and bathing, upper and lower body dressing, putting on/talking off footwear, and personal hygiene. The MDS further indicated that Resident 38 had an indwelling catheter. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 38's care plan for risk for UTI related to use of indwelling catheter initiated on 12/10/2024, the care plan indicated a goal that the resident will show no sign and symptoms of infection during every shift through the next review date. The care plan interventions were to change the indwelling catheter and the bag per facility`s policy, evaluate for pain, encourage fluids, and irrigate (washing out an organ by flushing it with a fluid) the indwelling catheter as ordered.  During a review of Resident 38's Physician Order Summary dated 1/7/2025, the order summary indicated that the resident`s indwelling catheter order for neurogenetic bladder (lack bladder control due to a brain, spinal cord or nerve problem) was discontinued on 1/7/2025 at 3:53 p.m. During a concurrent interview and record review 1/29/2025 at 10:30 a.m., with MDS Nurse 1 (MDSN 1), Resident 38`s care plans and physician orders were reviewed. MDSN 1 stated Resident 38 `s indwelling catheter order was discontinued on 1/7/2025. However, the care plan for indwelling catheter is still active and was not revise after removal of the indwelling catheter. MDSN 1 stated licensed staff are required to revise a resident`s care plan immediately after removal of the indwelling catheter. MDSN1 stated the potential outcome of not revising the resident's care plan is incorrect medical record and the inability to provide appropriate care and services to the resident. During an interview on 1/30/2025 at 2:05 p.m., with the Director of Nursing (DON), the DON stated licensed staff are required to update/revise a resident`s care plan for indwelling catheter immediately after removal of the catheter. The DON stated the residents` care plans need to reflect the correct condition of the residents with the current services and interventions that are being implemented. The DON stated the potential outcome of not updating/revising a resident`s care plan after removal of an indwelling catheter is the inability to provide appropriate care and services to the resident and incorrect medical records. During a review of the facility's Policy and Procedure (P&P) titled, Care Planning, last revised on 7/2024, the P&P indicated that the purpose of this policy is to assure a coordinated and comprehensive written plan is developed based on the resident assessment instrument and on the individual needs of the resident. It is the policy of this facility that within 24 hours of admission, a coordinated and comprehensive written plan is developed based on the resident assessment instrument and on the individual needs of the resident. Resident care planning includes participation from all involved health care disciplines at resident care conferences with continual reassessment, and updating at least quarterly, and upon change of condition, until resident's discharge. Reviews will be recorded by date in number sequence. Document resolution of the problem. When a problem is resolved the appropriate date will be indicated on the resident care plan.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. 44309 Based on interview, and record review the facility failed to follow the facility's Policy and Procedure (P&P) titled Discharge Planning, for one of two sampled residents (Resident 60) investigated under closed record review by failing to: 1. Develop a care plan (a document outlining a detailed approach to care customized to an individual resident's need) addressing Resident 60`s discharge plan.  2. Initiate a discharge planning assessment prior to Resident 60`s discharge. These deficient practices placed Resident 60 at risk for not receiving the necessary care and services related to the resident's discharge goals and needs. Findings: During a review of Resident 60's Patient Information Form (face sheet), the patient information form indicated that the facility admitted the resident on 11/9/2023, with diagnoses including tracheostomy (an opening surgically created through the neck into the windpipe to allow air to fill the lungs), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and seizure disorder (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a review of Resident 60's Minimum Data Set (MDS - a resident assessment tool) dated 11/14/2024, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 60 was dependent to staff (helper does all of the effort) for oral hygiene, toileting hygiene, upper and lower body dressing, putting on/talking off footwear, and personal hygiene. During a review of Resident 60`s Intradisciplinary Team (IDT- a group of healthcare workers from different health care disciplines to help people receive the care they need) Conference notes dated 10/28/2024, the IDT notes indicated no entries or documentations for psychosocial and discharge planning sections. During a review of Resident 60`s assessments, there was no discharge planning assessment conducted for the resident prior to his discharge on 12/22/2024. During a review of Resident 60's Order Summary Report (physician order) dated 12/22/2024, the order indicated to discharge the resident home with his medications on 12/22/2024. During a review of Resident 60`s Nursing Progress Notes dated 12/22/2024 at 3:57 p.m., the progress notes indicated that Resident 60 was discharged home with Family Member 1 (FM1) and the discharge instructions were provided to FM 1. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/30/2025 at 8:51 a.m., with Social Worker 1 (SW 1), Resident 60`s social service notes, assessments, IDT notes, and care plans were reviewed. SW 1 stated the last IDT conference held for Resident 60 was on 10/28/2024. However, there is no documentations regarding Resident 60`s discharge planning. SW1 stated that she (SW 1) was on medical leave at that time and unable to attend the meeting. SW 1 stated that there was no IDT meeting held addressing Resident 60`s discharge and discharge planning after 10/28/2024. SW 1 stated social service department is involved with the residents` discharge and any coordination required prior to their discharge from the facility. SW 1 stated she was involved with Resident 60`s discharge process. However, she did not document any notes regarding the resident`s discharge planning and all coordination completed prior to the resident`s discharge home. SW 1 stated she did not develop a care plan addressing Resident 60`s discharge plan. SW 1 stated there should be a care plan developed for the resident`s discharge upon admission and the care plan should be updated as needed. SW 1 stated it the facility policy for social workers to initiate a discharge planning assessment when the resident has a planned discharge. However, she (SW 1) did not initiate a discharge planning assessment for Resident 60. SW 1 stated it is important to comply with the facility`s discharge policy and procedure by documenting all the necessary discharge information and conducting required assessments prior to the resident`s discharge for a safe and effective discharge. During an interview on 1/30/2025 at 2:30 p.m., with the Director of Nursing (DON), the DON stated staff are required to follow the facility`s discharge planning policy and procedure. The DON stated Resident 60`s discharge planning was incomplete. The DON stated staff did not develop a care plan addressing Resident 60`s discharge needs. The DON stated there was no IDT conference held by the facility staff prior to the resident`s discharge home to discuss the resident`s discharge needs. The DON further stated that staff did not initiate and complete a discharge planning assessment prior to Resident 60`s discharge. The DON stated the potential outcome of an incomplete discharge planning is the lack of provision of the necessary discharge care and services to the resident. During a review of facility`s Policy and Procedure (P&P) titled Discharge Planning, last reviewed 7/2024, the P&P indicated that The IDT and discharge planner (social worker) are actively involved in planning for the residents who are about to be discharged . The social worker will document in the resident care plan section for discharge planning the level of care required for the resident. The level of care shall be documented within seven days of admit and updated as needed, quarterly and upon change of condition. The social worker shall initiate the discharge planning assessment when it is known that a resident anticipates being discharged . This may be on admission or any time a discharge to home, another facility, lower level of care, nursing facilities indicated. This form should be completed within seven days notice of the discharge. Once the need for discharge planning has been determined, the social worker is responsible for coordination with the resident/responsible party and appropriate disciplines/services the team`s development and completion of the post discharge plan of care summary. Upon discharge the completed discharge forms will be maintained in the medical record.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469 Based on interview and record review the facility failed to follow the physician's order by failing to check a resident's orthostatic hypotension (a condition where blood pressure drops significantly upon standing or sitting up from a lying position) on 10/23/2024 and 11/27/2024 for one of one (Resident 33) sampled resident. This deficient practice had the potential for Resident 33 to experience dizziness, lightheadedness, or even fainting when standing up, which can lead to falls and injury. Findings: During a review of Resident 33's Patient Information, the Patient Information indicated that the facility admitted the resident on 8/17/2021. During a review of Resident 33`s History and Physical (H&P- the most formal and complete assessment of the patient and the problem) dated 1/20/2024, the H&P indicated that the resident had the following diagnoses, including: a. Dysphagia (difficulty swallowing) b. bipolar disorder (a mental health condition where you have extreme mood changes) c. Schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). During a review of Resident 33's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 11/25/2024, the MDS indicated that the resident`s cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact. The MDS indicated that the resident required supervision during shower, upper body and lower body dressing, putting on/taking off footwear and dependent on staff for toileting hygiene. During a review of Resident 33`s Fall Risk assessment dated [DATE], the Fall Risk Assessment indicated that the resident is high risk for fall.  During a review of Resident 33`s Physician`s Order (PO) dated 2/3/2023, the Physician's Order indicated that the resident will be monitored for side effects of Zoloft every shift and monitor for orthostatic hypotension on 7:00 a.m. to 7:00 p.m. shift for 14 days then weekly.  During a review of Resident 33`s Physician`s Order dated 1/3/2025, the Physician's Order indicated a renewed order for Zoloft Oral Tablet 50 milligram (mg) one tablet by mouth in the morning for depression manifested by verbalization of sad feelings. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 33`s Medication Administration Records (MAR- used to document medications taken by each individual) for the month of October 2024 and November 2024, the MAR indicated that a section/column that indicated 2/2/23 Monitor for orthostatic hypotension from 7a-7p sitting/lying position weekly on Wednesday. The MAR for the month October 2024 was blank on the week of 10/21/2024 (Monday) to 10/27/2024 (Sunday) and November 2024 week of 11/25/2024 (Monday) to 11/30/2024 (Sunday). During a concurrent interview and record review on 1/29/2025 at 10:34 a.m., with Registered Nurse 1 (RN 1), reviewed Resident 33`s physician`s order for Zoloft, the order to monitor for orthostatic hypotension and the MAR for October 2024 and November 2024. RN 1 stated monitoring for orthostatic hypotension is done for residents on certain medications, including Zoloft. RN 1 stated that monitoring for orthostatic hypotension is important to prevent a fall incident, potentially resulting in injuries if the resident`s blood pressure drops, or the resident becomes hypotensive (low blood pressure) due to the medication. RN 1 stated that licensed nurses should have checked the resident for orthostatic hypotension and document in the MAR on 10/23/2024 and 11/27/2024 to ensure Resident 33's blood pressure was not low. During a review of the facility`s policy and procedure, titled Pharmaceutical Services Policy and Procedure Manual, last reviewed on 7/2024, the policy indicated that residents who receives antidepressant, hypnotic, antianxiety, or antipsychotic medications shall be monitored to evaluate the effectiveness of the medication. Every effort is made to ensure that residents receiving these medications obtain the maximum benefit with minimum untoward effects . physician, nurse, or other health professional documentation that the resident is being monitored for adverse consequences of therapy .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44309 Based on observation, interview, and record review, the facility failed to implement accident risk and hazard interventions for three of five sampled residents (Residents 30, Resident 34, and Resident 18) by failing to: 1. Ensure padding was applied to Resident 30 and 34`s bed side rails for seizure precaution (the safety measures taken before an individual experiences a seizure).  2. Repair or replace Resident 18`s broken wheelchair. These deficient practices had the potential to place Residents 30, 34 and 18 at risk for injuries. Findings: 1.a During a review of Resident 30's History and Physical (H&P) dated 7/1/2024, the H&P indicated that the facility admitted the resident on 7/15/2022, with diagnoses including tracheostomy (an opening surgically created through the neck into the windpipe to allow air to fill the lungs), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and seizure disorder (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a review of Resident 30's Minimum Data Set (MDS - a resident assessment tool) dated 1/23/2025, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 30 was dependent to staff (helper does all of the effort) for oral hygiene, toileting hygiene, upper and lower body dressing, Showering/ bathing, and personal hygiene. The MDS indicated that Resident 30 had a diagnosis of seizure disorder. During a review of Resident 30's Medication Review Report (physician order), dated 3/7/2023, the medication review report indicated to apply bilateral (both sides) padding to the resident`s side rails at all times. During a review of Resident 30's care plan (a document outlining a detailed approach to care customized to an individual resident's need) for risk for seizure activity, initiated on 8/24/2023 and last revised on 8/12/2024, the care plan indicated a goal that Resident 30 will not experience any seizure activity. The care plan interventions were to administer medication as ordered, implement seizure precautions per facility guidelines, keep bed side rails up while in bed to prevent from falling, and monitor for sign and symptoms of seizure activity. During an observation on 1/27/2025 at 11:15 a.m., inside Resident 30`s room, Resident 30 was observed lying on his bed. Resident 30's bed side rails did not have any padding as a precaution for seizures. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 6/22/2024 at 11:33 a.m., with Licensed Vocational Nurse 2 (LVN 2), observed Resident 30's bed side rails without any padding. LVN 2 stated Resident 30's bed side rails were not padded. LVN 2 stated Resident 30's is supposed to have padded side rails in place because he has a diagnosis of seizure. LVN 2 stated the padded side rails protect the resident from injuries in the event of a seizure. 1.b During a review of Resident 34's physician`s History and Physical (H&P) dated 7/1/2024, the H&P indicated that the facility admitted the resident on 2/3/2022, with diagnoses including tracheostomy, gastrostomy, and seizure disorder. During a review of Resident 34's MDS dated [DATE], the MDS indicated that the resident was at persistent vegetative state (a chronic disorder in which an individual with severe brain damage appears to be awake but shows no evidence of awareness of their surroundings). The MDS indicated that Resident 34 was dependent to staff (helper does all of the effort) for oral hygiene, toileting hygiene, upper and lower body dressing, Showering/ bathing, and personal hygiene. The MDS indicated that Resident 34 had a diagnosis of seizure disorder. During a review of Resident 34's Medication Review Report (physician order), dated 3/7/2023, the medication review report indicated to apply bilateral padding to the resident`s side rails at all times. During a review of Resident 34's care plan for risk for seizure activity, initiated on 7/14/2023, and last revised on 8/9/2024, the care plan indicated a goal that Resident 34 will not experience seizure activity. The care plan interventions were to administer medication as ordered, implement seizure precautions per facility guidelines, keep bed side rails up at all times, monitor the resident for complications such as resident getting hurt by side rails if seizure occurs, and monitor for sign and symptoms of seizure activity. During a concurrent observation and interview on 1/27/2024 at 11:38 a.m., with LVN 2, Resident 34's bed rails were observed. LVN 2 stated Resident 34's bed side rails must be padded as ordered by the physician to prevent the resident from injuries if the resident has a seizure. During an interview on 1/30/2025 at 2:22 p.m., with the Director of Nursing (DON), the DON stated staff are required to follow physician orders for seizure precautions. The DON stated Residents 30 and 34 had orders for padded sided rails and these orders were not implemented by the staff. The DON stated the potential outcome is injuries during seizure activity. 2. During a review of Resident 18's Patient Information Form (face sheet), the information form indicated that the facility admitted the resident on 11/4/2016, with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and dysphagia (difficulty swallowing). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 18's MDS dated [DATE], the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was intact (decisions consistent/reasonable). The MDS indicated that Resident 18 required partial/moderate assistance (helper does less than half the effort) for toileting hygiene, chair/bed-to-chair transfer (the ability to transfer to and from a bed to a chair or wheelchair), and sit to stand (the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed). The MDS indicated that Resident 18 had limitation in Range of Motion (ROM- full movement potential of a joint) on one side of his body. During a review of Resident 18's care plan for risk for injury from falls related to right sided weakness, initiated on 6/26/2023, and last revised on 12/27/2024, the care plan indicated a goal that Resident 18 will free of falls during every shift. The care plan interventions were to ensure the bed is kept in the lowest position, evaluate the resident`s environment to identify factors known to increase risk of falls and educate on the importance of maintaining a safe environment, free of potential fall hazards. During a resident council meeting conducted on 1/28/2025 at 10:36 p.m., Resident 18, present at the meeting, voiced a concern regarding his broken wheelchair hand break. During a concurrent observation and interview on 1/28/2025 at 3:02 p.m., inside Resident 18`s room, Resident 18 was observed lying on his bed and his wheelchair was placed to the left of the bed. Resident 18`s wheelchair had an arm and footrest on the right side but did not have either on the left side. A green rubber band was observed connecting the right-hand break to the right arms rest. Resident 18 stated that his wheelchair hand break has been broken for two (2) weeks. Resident 18 stated that he has placed the green rubber band on his wheelchair to hold the hand break in place. Resident 18 stated that it is difficult for him to use the hand break because it is broken. Resident 18 stated he has voiced his concern regarding the broken hand break to nursing staff. Resident 18 stated that his wheelchair was previously sent to the engineering department for repair. However, even after the repair, the wheelchair hand break fails to function properly. During a concurrent observation and interview on 1/28/2025 at 3:10 p.m., with Registered Nurse 1 (RN1), Resident 18 `s wheelchair was observed. RN 1 stated she (RN) has seen the green rubber band on the resident`s wheelchair and she is aware that the right-hand break is broken. RN 1 attempted to reposition Resident 18`s wheelchair right footrest and it fell down. RN 1 stated the footrest is broken as well. RN 1 stated that about two months ago Resident 18 reported to her regarding the broken hand break on his wheelchair. RN 1 stated that she sent the resident`s wheelchair to engineering for repair. RN 1 stated she did not follow up to see whether or not the hand break on Resident 18`s wheelchair was functioning properly. RN 1 stated that staff is required to monitor a resident`s wheelchair to ensure that it is properly functioning at all times. RN 1 stated that the potential outcome of a resident using a wheelchair without a properly functioning hand break and footrest is a fall, potentially resulting in injuries to the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/30/2025 at 2:35 p.m., with the DON, the DON stated staff are required to monitor a resident`s mobility devices such as cane, and wheelchair to ensure the devices are functioning properly and safe to use. The DON stated Resident 18`s wheelchair hand break and footrest were broken, and staff did not conduct any interventions to repair or replace it immediately. The DON stated Resident 18 was given a new wheelchair on 1/28/2025 after the concern was [NAME] up by the surveyor. The DON stated that the potential outcome of a resident using a wheelchair without a properly functioning hand break and footrest is a fall and possible injuries to the resident. During a review of the facility's Policy and Procedure (P&P) titled, Seizure Precautions, revised 8/2024, the P&P indicated that it is the policy of the facility t provide preventative measures prior to and during seizure activity to prevent resident injury to the extent possible. Identify residents with potentials for seizure activity on the resident`s care plan. Provide safe environment. Pad side rails as indicated. During a review of the facility's Policy and Procedure (P&P) titled, Safety Precautions-Nursing Services, revised 12/2009, the P&P indicated that the following safety precautions have been established for all personnel to follow when providing nursing care/services. Reports unsafe acts or conditions to your supervisor as soon as possible and report all broken or defective equipment to your supervisor.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 38469 Based on observation, interview, and record review the facility failed to: 1. Check the gastrostomy tube (G-tube, a tube inserted through the abdomen] to deliver nutrition and medications directly to the stomach]) residual volume (the amount of fluid in the stomach after a feeding) before administering a medication to one of five residents (Resident 7) observed during medication administration This deficient practice had the potential to place Resident 7 at increased risk for aspiration pneumonia (a type of lung infection that occurs when food, saliva, or other substances are inhaled into the lungs, which occurs when medication is accidentally delivered into the lungs instead of the stomach because an improperly placed tube could be in the esophagus or trachea, allowing medication to enter the airway). 2. Ensure the G-tube (G-tube - a flexible tube surgically inserted through the abdomen into the stomach for feeding, fluid, and medication administration) feeding bottle was labeled with the date and time the feeding was started for one of 41 residents (Resident 48) prescribed with G-tube feeding. This deficient practice placed Resident 48 at risk for infection from spoiled G-tube feeding formula since it was unknown when the G-tube feeding bottle was changed or started. 3. Failed to label the feeding syringe (a medication device that helps deliver nutrients, medications, or fluid directly into a patient's digestive system through a feeding tube) with the resident's name and the date it was last changed for one of four of four sampled residents (Residents 52) reviewed under tube feeding (feeding delivered through a medical device bypassing oral intake) This deficient practice had the potential to increase the risk of healthcare acquired infection to Resident 52. 4. Implement their enteral tube feeding (a method of supplying nutrition directly into the stomach) policy by failing to ensure that one of three sampled resident's (Resident 19) gastrostomy tube (GT-a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) feeding formula was labeled with the time, date, and initials of the licensed nurse who initiated the feeding formula. This deficient practice had the potential to result in the feeding formula exceeding its hang-time (the amount of time a prepared tube feeding formula can safely remain at room temperature before it needs to be discarded) and may have the potential to cause adverse reactions (an undesired effect of a treatment) such as upset stomach and/or diarrhea (loose stool). Findings: (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. During a review of Resident 7's Patient Information, the Patient Information indicated the facility originally admitted the resident on 1/21/2024 and readmitted on [DATE], with diagnoses including chronic respiratory failure (a condition in which the lungs are unable to adequately exchange oxygen and carbon dioxide over a prolonged period) and persistent vegetative state (a chronic state of brain dysfunction in which a person shows no signs of awareness). During a review of Resident 7`s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 12/13/2024, the MDS indicated Resident 7's is in a persistent vegetative state (comatose). The MDS indicated that Resident 7 was totally dependent on staff for self-care.  During a review of Resident 7`s Physician`s order dated 2/27/2024, it indicated an order for Tramadol HCL Tablet 50 milligram (mg), give 1 tablet via G-Tube every 6 hours as needed for moderate to severe pain. During a medication observation and concurrent interview on 1/28/25 at 4:18 p.m., observed Licensed Vocational Nurse 1 (LVN1) prepared Tramadol 50 mg for Resident 7. Observed LVN 1 enter the resident`s room, greeted the resident, introduced himself, checked the resident`s ankle band and explained to the resident that he (LVN 1) administer Tramadol 50 mg. LVN 1 washed his hands after he placed the resident in semi-Fowler position. LVN 1 flushed Resident 7's G-tube with water and gave the medication through the medication syringe attach to the G-Tube port. After giving the resident the medication, LVN 1, stated that he should have verified the G-tube placement by aspirating for gastric contents and withheld the medication if the gastric residual (the volume of fluid remaining in the stomach after a meal or during enteral feeding) exceeded 100 milliliters (ml.-unit of measurement). LVN1 stated that it is important to check for gastric residual to confirm the G-Tube's placement and prevent aspiration pneumonia. During a review of the facility`s policy and procedure titled Medication Administration, last reviewed on 11/2022, the policy indicated in the procedure that for tube administration, check for proper placement of tube by aspirating gastric contents; flush the tube with approximately 30 ml of water; draw the liquefied medications into the feeding syringe or pour into connected feeding syringe by gravity; and allow medications to flow by gravity through the enteral tube . 2. During a review of Resident 48's Patient Information, the Patient Information indicated that the facility admitted the resident on 2/16/2024. During a review of Resident 48`s History and Physical (H&P- the most formal and complete assessment of the patient and the problem) dated 2/19/2024, the H&P indicated that the resident had multiple diagnoses including dysphagia (difficulty swallowing) and multiple fracture. During a review of Resident 48's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 11/21/2024, the MDS indicated Resident 48 is in a persistent vegetative state (comatose). The MDS indicated that Resident 48 was totally dependent on staff for self-care. During a review of Resident 48`s Physician`s Order (PO) dated 8/26/2024, the PO indicated an order for G-Tube feeding of Glucerna 1.2 at 75 milliliter (ml) per hour via enteral pump (enteral pumps are used when a tube feeding needs to be administered slowly over an extended period of time). (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 01/27/25 11:34 a.m., with Licensed Vocational Nurse 2 (LVN2), observed Resident 48`s G-Tube feeding formula bottle without date and time it was started. LVN 2 stated the formula should have a label indicating the rate of infusion, room number, and the date and time the feeding formula was hung and started. LVN 2 stated that it is important to label the formula with the date and time because the formula should only be used for 24 hours. LVN 2 stated that if the feeding formula has been hung for more than 24 hours, there is a risk that the resident may receive spoiled formula, potentially causing stomach illnesses to Resident 48. During an interview with Registered Nurse 1(RN 1) on 01/28/25 11:11 a.m., RN 1 stated that if the feeding formula is not labeled with the time it was hung, they will not be able to determine if the feeding formula has been in use for more than 24 hours. RN 1 stated the feeding formula must be discarded after 24 hours for infection control and to prevent foodborne illnesses During a review of the facility`s policy and procedure, titled Enteral Feeding via G-Tube, last reviewed on 11/2024, the policy indicated to Fill and connect bag and tubing. DO NOT fill with more formula than will be administered in four hours. If using closed system, formula may hang for 24 hours. Label bag with date and time hung. 47883 3. During a review of Resident 52's Inpatient Registration Form, the Inpatient Registration Form indicated that the facility admitted Resident 52 on 10/9/2024 and readmitted the resident on 10/15/2024. During a review of Resident 52's History and Physical (H&P), dated 10/16/2024, the H&P indicated the resident was admitted with diagnoses including hypertension (a condition in which blood pressure is higher than normal), chronic respiratory failure status post tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea [windpipe] from outside the neck), and dysphagia (difficulty swallowing). The H&P indicated that Resident 52 did not have a capacity to make decisions. During a review of Resident 52's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 4/26/2024, the MDS indicated that the resident had severely impaired cognition (severely damaged mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS further indicated that Resident 52 was totally dependent on staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During the review of Resident 52's Order Summary Report, the Order Summary Report indicated an order dated 10/15/2024 for Jevity 1.2 (feeding formula) at 50 cc/hours (rate of infusion of feeding formula) for 22 hours to provide 1320 cc/day (number of calories for 24 hours) via G-Tube. During the review of Resident 52's care plan (a document that outlines the actions and interventions needed to address a resident's health and care needs) regarding gastrostomy status revised on 1/28/2025 the care plan indicated that goal of care plan was to minimize risk of infection at G-Tube site. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 1/27/2025 at 12:15 p.m. in Resident 52's room, observed a feeding syringe in an open package and did not have a label indicating the resident's name and the date it was last changed. During an interview on 1/27/2025 at 12:16 p.m., Registered Nurse 3 (RN 3) confirmed that Resident's 52 feeding syringe was not labeled with a name and the date it was changed. RN 3 stated the feeding syringe should be labeled with the resident's name and the date it was last changed to prevent cross contamination and decrease risk of healthcare acquired infection to Resident 52. During an interview on 1/28/2025 at 4:13 p.m. with the (DSD), the DSD stated that the feeding syringe should be labeled with the resident's name and the date it was last changed to prevent microbial growths and cross contamination. The DSD stated that this deficient practice had the potential for increased risk of infection to Resident 52. During an interview on 1/30/2025 at 7:43 a.m. with the Infection Preventionist (IP), the IP stated that the feeding syringe has to be changed every 24 hours and labeled with the date it was changed and the resident's name to prevent microbial growths and cross contamination. The IP stated that this deficient practice has the potential for increased risk of healthcare acquired infection to Resident 52. During a review of the facility policy named Enteral Feeding via G-tube or G-Tube (continuous) pump, last reviewed on 11/2024, the policy stated: Enteral feeding will be administered by a continues method via pump as ordered by the physician, and per facility standards .Change feeding bag and tubing every 24 hours. 44309 4. During a review of Resident 19's History and Physical (H&P) dated 7/1/2024, the H&P indicated that the facility admitted the resident on 2/18/2022, with diagnoses including tracheostomy (an opening surgically created through the neck into the windpipe to allow air to fill the lungs), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and seizure disorder (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a review of Resident 19's Minimum Data Set (MDS - a resident assessment tool) dated 11/22/2024, the MDS indicated that the resident was at persistent vegetative state (a chronic disorder in which an individual with severe brain damage appears to be awake but shows no evidence of awareness of their surroundings). The MDS indicated that Resident 19 was dependent on staff (helper does all of the effort) for oral hygiene, toileting hygiene, showering and bathing, upper and lower body dressing, and personal hygiene. The MDS further indicated that Resident 19 was receiving nutrition via gastrostomy tube. During a review of Resident 19`s Medication Review Report (physician order) dated 11/25/2024, the medication review report indicated an order for Glucerna 1.2 (type of enteral feeding) at 50 ml (milliliter- unit of measurement)/hr. (hour) for eighteen hours via enteral pump. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 1/27/2025 at 9:36 a.m., with Licensed Vocational Nurse 5 (LVN 5), inside Resident 19's room, LVN 5 stated that Resident 19`s GT formula and water bags did not have a label with the date and time the feeding was started nor the initials of the nurse who started the feeding. LVN 5 stated when licensed nurses start a new feeding bag, they are required to label the feeding bag with the date and time the feeding was started and mark their initials on the label. LVN 5 stated this is to ensure that the formula is safe for the resident. During an interview on 1/30/2025 at 2:24 p.m., with the Director of Nursing (DON), the DON stated that all feeding bags and bottles should be labeled with the resident's name, type of feeding, rate, date and time and initial of the licensed nurse who hung the feeding. The DON stated the date and time are important to be labeled because feeding bags and tubing must be changed and discarded every 24 hours per facility`s policy. The DON stated the potential outcome of not properly labeling a tube feeding bag is the inability to know the date and time the feeding was started.  During a review of the facility`s Policy and Procedure (P&P) titled Enteral Feeding Via G-Tube) last reviewed 11/2024, the P&P indicated that enteral feeding will be administered by a continuous method via pump as ordered by the physician, and per facility`s standard. Change feeding bag and tubing every 24 hours.

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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** 34659 Based on interview and record review, the facility failed to ensure residents' pain was assessed before and after administration of pain medication for two of two sampled residents (Resident 6 and Resident 42). This deficient practice resulted in Resident 6 and Resident 42's pain not being assessed and placed the residents at risk for having unmanaged pain that may diminish the residents' quality of life. Cross reference F755 Findings: a. During a review of Resident 6's Patient Information Form (a page with information indicated for a resident such as facility admitted and pertinent diagnoses), the document indicated the resident was admitted to the facility on [DATE] with diagnoses that included respiratory failure (condition when the lungs cannot get enough oxygen into the blood). During a review of Resident 6' s Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 1/09/2025, the MDS indicated Resident 6 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 6 was dependent on staff for oral hygiene, toileting, dressing, and personal hygiene. During a review of Resident 6's Physician's Orders, the documents indicated the following orders: - Hydrocodone acetaminophen tablet (brand name is Norco, a narcotic pain medication) 10-325 milligrams (mg, a unit of measure), give one tablet by gastrostomy tube (G-Tube, a plastic tube inserted into the stomach to give medications for those with difficulty swallowing) every four hours as needed (PRN, or pro re nata, Latin for as needed) for severe pain 7-10, (numeric pain scale in which a resident's pain is indicated with zero being no pain and 10 for the worst pain imaginable), dated 7/24/2024. During a review of Resident 6's CDR, the document indicated the medication Norco was removed from the blister pack (or called bubble pack, a card that packages doses of medication within small, clear, plastic bubbles [or blisters] that is punched out to administer to a resident) on the following dates: 1/28/2025 at 4:20 a.m. 1/26/2025 at 6 a.m. 1/24/2025 at 6 a.m. 1/23/2025 at 11 p.m. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 6's MAR for the month of 1/2025, the MAR did not indicate Resident 6 was given Norco on the above dates. The MAR did not indicate any documentation that Resident 6's pain was assessed for these dates. b. During a review of Resident 42's Patient Information Form, the document indicated the resident was admitted to the facility on [DATE] with diagnoses that included acute respiratory failure with hypoxia (a serious condition that occurs when the lungs are unable to exchange oxygen and carbon dioxide [a by-product of respiration] efficiently with the blood). During a review of Resident 42's MDS, dated [DATE], the MDS indicated Resident 42 was cognitively intact with skills required for daily decision making. The MDS indicated Resident 42 required setup or clean-up assistance (helper sets up or cleans up) with eating and oral hygiene. The MDS indicated Resident 42 had a diagnosis of pain. During a review of Resident 42's Physician's Orders, the documents indicated the following orders: -Norco 5-325 mg, give one tablet by mouth every eight hours as needed for severe pain 7-10, dated 5/19/2023. During a review of Resident 42's CDR, the CDR indicated the medication Norco was removed from the blister pack on 1/24/2025 at 9 p.m. The MAR did not indicate any documentation that Resident 6's pain was assessed for these dates. During a review of Resident 42's MAR for the month of 1/2025, the MAR did not indicate Resident 42 was given Norco on 1/24/2025 at 9 p.m. The MAR did not indicate any documentation that Resident 6's pain was assessed for these dates. During a medication cart observation and concurrent record review with Registered Nurse 1 (RN 1) on 1/28/2025 at 9:08 a.m., observed the contents of Subacute 2 Medication cart 3. Reviewed Resident 6's CDR for Norco which indicated Norco was signed out to be given to Resident 6 on 1/28/2025 at 4:20 a.m., 1/26/2025 at 6 a.m., 1/24/2025 at 6 a.m., and 1/23/2025 at 11 p.m. However, there was no corresponding entry in Resident 6's 1/2025 MAR. RN 1 stated the process is that when a controlled drug is removed from the bubble pack, the licensed nurse is to sign the controlled drug record, give the medication to the resident, and then sign the MAR. RN 1 stated the licensed nurse should have signed the MAR after giving the medication. RN 1 stated this process is important so that a resident's physician knows how much medication is being given and will indicate whether a resident's pain relief is achieved. Also in Subacute 2 Medication Cart 3, reviewed Resident 42's CDR for Norco which indicated Norco was signed out to be given to Resident 42 on 1/24/2025 at 9 p.m. However, there was no corresponding entry in Resident 42's 1/2025 MAR. During an interview with the Director of Staff Development (DSD) on 1/29/2025 2:45 p.m., they stated the licensed nurse who signed the CDR but not the MAR for Resident 6 and Resident 42 worked the 7 p.m. to 7 a.m. shift. Asked for name and contact information for the licensed nurse but did not receive during the recertification survey. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DSD on 1/30/2025 at 12:20 p.m., they stated the process is that when a controlled drug is removed from the bubble pack, the licensed nurse is to sign the controlled drug record, give the medication to the resident, and then sign the MAR. The DSD stated this was important to know if the pain medication was effective, and if not affective to notify the doctor to receive an order to modify the dosage. During an interview and concurrent record review with the Director of Nurses (DON) on 1/30/2025 at 2:14 p. m., they stated the process is that when a controlled drug is removed from the bubble pack, the licensed nurse is to sign the controlled drug record, give the medication to the resident, and then sign the MAR. The DON stated they thought the pain medications removed for Resident 6 and Resident 42 and were documented on the CDRs were given to them. The DON stated they did not think there was an issue of drug diversion. The DON stated it is important to sign the MAR because for pain medication there is a pain level documented and if not signed in the MAR, then no assessment or reassessment of the effectiveness of the pain medication. The DON stated this had the potential to result in a resident's pain will not be relieved. The DON stated if there was no documentation on the MAR, then the pain was not assessed for those times. During a review of the facility's policy and procedure titled, Controlled Drug Management on Patient Care Units, last reviewed 7/2024, the policy and procedure indicated when a medication is removed from stock, the narcotic drug record sheet is completed to indicated date, time, patient's name, room number, the quantity removed and the signature of a nurse administering the medication. During a review of the facility's policy and procedure titled, Controlled Medications, last reviewed 7/2024, the policy and procedure indicated the following: When a controlled medication is administered, the licensed nurse administering the medication shall immediately enter the following information on the accountability record: 1) Date and time of administration 2) Amount administered 3) Signature of the nurse administering the dose, completed after the medication is actually administered Note: Entering information on the accountability record does not replace recording medication administration on the MAR. During a review of the facility's policy and procedure titled, Medication Administration, reviewed 7/2024, the policy and procedure indicated the following: The individual who administers the medication dose shall record the administration of the resident's MAR directly after the medication is given. When PRN medications are administered, the following documentation shall be provided: 1) Date and time of administration, dose, route of administration (if other than oral). (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Complaints or symptoms for which the medication was given. 3) Results achieved from giving the dose and the time results were noted. 4) Signature of initials of person recording administration and signature or initials of person recording effects, if different from the person administering the medication.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34659 Based on interview and record review, the facility failed to ensure the physician sign and date all orders in the physical or electronic record, during visits of three out of 23 sampled residents (Resident 4, Resident 13, and Resident 51). This deficient practice had the potential to cause a delay in a resident's plan of care. Findings: a. During a review of Resident 4's Patient Information Form (a page with information indicated for a resident such as facility admitted and pertinent diagnoses), the document indicated the resident was admitted to the facility on [DATE] with diagnoses that included respiratory failure (condition when the lungs cannot get enough oxygen into the blood). During a review of Resident 4' s Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 12/18/2024, the MDS indicated Resident 4 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 6 was dependent on staff for oral hygiene, toileting, dressing, and personal hygiene. The MDS indicated Resident 4 had a diagnosis for seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a review of Resident 4's paper Physician's Orders, the documents indicated the following telephone orders that were not signed by a physician, nor was there a date or time indicated: - Physical therapy/Occupational evaluation (evaluating use of arms and legs). - Recommend Restorative Nursing Assistant Program (RNA, a nurse who helps in moving a resident's arms and legs to maintain a resident's functioning) for bilateral (both) upper extremity (arms) maintenance. - RNA to perform Passive Range of Motion Exercises (PROM, when a nurse moves a resident's arms and legs for those who cannot move them) exercises to bilateral upper extremities and bilateral lower extremities as tolerated five times a week for 90 days. - RNA/Nursing to apply right elbow splint (a device that holds the elbow in place) per protocol. - RNA/Nursing to apply bilateral ankle foot orthosis (a brace worn to provide support) AFO's per protocol. b. During a review of Resident 13's Patient Information Form, the document indicated Resident 13 was admitted to the facility on [DATE]. No diagnoses were indicated on the Face Sheet. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 13's MDS, dated [DATE], the MDS indicated Resident 13 was cognitively intact with skills required for daily decision making. The MDS indicated Resident 13 was independent (resident completes the activity by themselves with no assistance from a helper) with eating and oral hygiene. The MDS indicated Resident 13 had a diagnoses of diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and anemia (a condition where the body does not have enough healthy red blood cells) During a review of Resident 13's paper Physician's Orders, the documents indicated the following orders without a date or time on them: - Zepbound (a medication to help one to lose weight) 7.5 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) once a week for four weeks, followed by Zepbound 10 mg once a week for four weeks followed by Zepbound 12 mg once a week for four weeks followed by Zepbound 15 mg once a week as maintenance dosage (medication required to maintain a desired steady-state drug concentration in the body). - Laboratory values hemoglobin A1C (Hgb A1C, a blood test that measures the average blood sugar [glucose] level over the past 2-3 months) - Loratadine (medication to treat allergy to pollen or dust) 10 mg daily. - Discontinue Flonase (treats allergy symptoms). - Debrox (medication for ear wax removal) 4 drops twice a day for four days, manual ear flushing. - Laboratory values: uric acid, CBC, BMP - Venous ultrasound to rule out deep vein thrombosis (DVT, a blood clot that forms in the deep veins such as the legs that can travel to the lungs and stop breathing) ankle brachial index (ABI, ultrasound device to measure blood pressure in the ankle to see if there is any blood vessel blockage) bilateral lower extremities (both legs). - X-ray left lower leg. c. During a review of Resident 51's Face Sheet, the face sheet indicated Resident 51 was admitted to the facility on [DATE] with a diagnosis of acute respiratory failure (condition when the lungs cannot get enough oxygen into the blood). During a review of Resident 51's MDS, dated [DATE], the MDS indicated Resident 51 was severely impaired in cognition with skills required for daily decision making. The MDS indicated Resident 51 was dependent on staff with oral hygiene, dressing, toileting, and personal hygiene. During a review of Resident 51's paper Physician's Orders, the document indicated an order to draw labs for iron (a mineral that the body needs to produce hemoglobin [a protein in red blood cells that carries oxygen]) and ferritin (a protein in the blood that stores iron) without a date or time on them. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review with the Director of Staff Development (DSD) on 1/30/2025 at 12:20 p.m., reviewed Physician's Orders for Resident 4, Resident 13, and Resident 51. The DSD confirmed that none of the orders were dated or timed. The DSD confirmed that Resident 4's Physician Orders were not signed by the resident's physician. The DSD stated the process is for a resident's physician signs, dates, and times the physical order record or if the order is a telephone order, the nurse dates and times the order and the doctor comes to the nurse's station to sign the physical telephone order. The DSD stated after that, the licensed nurse enters the order into the electronic health record in the computer. The DSD stated this is important to ensure that a resident's orders are current, medications have the correct dosages and helping in tracking orders to see if they are completed. Reviewed Resident 4's Physician's Orders for RNA and the electronic order for RNA. The DSD confirmed, according to the RNA electronic order, the RNA orders were carried out 8/01/2024. Reviewed Resident 51's Laboratory Values for iron and ferritin, dated 12/18/2024. The DSD stated 12/18/2024 was the date the physical order for Resident 51 was written for the order of iron and ferritin. During an interview with the Director of Nurses (DON), on 1/30/2025 at 2:14 p.m., he stated a resident's physical orders need to be dated and timed by the resident's physician. The DON stated this is important, so the licensed nurses know when the order was written. The DON stated if the order is not entered directly into the electronic health record system the day the order was taken, there could be a delay in care for a resident. During a review of the facility's policy and procedure titled, Prescriber Medication Orders, last reviewed 7/2024, the policy and procedure indicated the following: Medications shall be administered only upon the clear, complete, and signed order of a licensed physician lawfully authorized to prescribe medications. Telephone orders are received only by licensed nurses or pharmacists and countersigned by the prescriber within the time prescribed by facility policy but in any even no later than 5 (five) days following generation of the telephone order. Each medication order shall be written in the resident's medical record with the date, time, and signature of the person writing or receiving the order.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on interview and record review, the facility failed to implement its policy and procedure titled, Patient Care Services-Assessment, for one of two sampled residents (Resident 46) by failing to conduct a social service assessment within 48 hours of the resident`s admission to the facility. This deficient practice placed the residents at risk of not receiving sufficient and appropriate social services to meet the resident's needs. Findings: During a review of Resident 46's History and Physical (H&P) dated 9/19/2024, the H&P indicated that the facility admitted the resident on 9/19/2024, with diagnoses including stroke (a loss of blood flow to part of the brain, which damages brain tissue), tracheostomy (an opening surgically created through the neck into the windpipe to allow air to fill the lungs), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and seizure disorder (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a review of Resident 46's Minimum Data Set (MDS - a resident assessment tool) dated 12/20/2024, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was intact (decisions consistent/reasonable). The MDS indicated that Resident 46 was dependent on staff (helper does all of the effort) for oral hygiene, toileting hygiene, upper and lower body dressing, putting on/talking off footwear, and personal hygiene. During an interview on 1/29/2025 at 1:00 p.m., inside Resident 46`s room, Resident 46 stated that she was admitted to the facility on [DATE]. However, she (Resident 46) has not seen a social worker in the facility since her admission. Resident 46 stated that she did not have any social services needs to be addressed but she (Resident 46) is aware that the social worker is required to visit her (Resident 46) upon her admission to the facility. During a concurrent interview and record review on 1/29/2025 at 1:35 p.m., with Social Worker 1 (SW 1), Resident 46`s assessments were reviewed. SW 1 stated that Resident 46 was admitted to the facility on [DATE]. However, she (SW 1) did not conduct any social service assessments for the resident since her admission. SW 1 stated the social workers are required to meet with the residents or their families within 24 hours of their admission and gather information necessary to conduct an initial assessment within 48 hours of the resident`s admission. SW1 stated that this assessment includes psychosocial history, physical, cultural and spiritual factors having impact on the resident`s adjustment and wellbeing in the facility, and the determination of anticipated discharge planning. SW 1 stated that the reason she did not conduct a social service assessment for Resident 46 was because she was backed up with assignments for other residents. SW1 stated that the potential outcome of not timely assessing a resident is the delay in addressing their psychosocial issues and assisting the residents with their adjustment period in the facility. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/30/2025 at 2:15 p.m., with the Director of Nursing (DON), the DON stated the social worker should visit the residents within 24 hours of their admission into the facility and shall conduct a social service assessment within 48 hours of the admission. The DON stated SW 1 did not conduct any social service assessments for Resident 46 and the potential outcome is inability to address psychosocial concerns, prevent psychosocial issues, provide safe discharge, and assist residents with their adjustment period in the facility. During review of the facility's Policy and Procedure (P&P) titled, Patient Care Services-Assessments, last reviewed on 7/2024, the P&P indicated that a social service assessment will be conducted within 24 hours of the resident`s admission with written assessment/documentation completed within 48 hours of the admission to the unit. Psychosocial information should be gathered that is pertinent to successful medical treatment, significant personal and social problems, emotional well-being and the resident`s ability for successful utilization of facility services. The purpose of the social service assessment shall be to understand those factors in the resident`s history, family situation and illness that affect the resident and his family in accepting and adjusting to the resident`s current situation and his need for placement on the subacute unit.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34659 Based on interview and record review, the facility failed to: 1. Ensure the Controlled Drug Record (CDR- accountability record of medications that are considered to have a strong potential for abuse) coincided with the Medication Administration Records (MAR) affecting Resident 6 and Resident 42 in one of three inspected medication carts (subacute unit two medication cart 3). This deficient practice had the potential to result in medication error and/or drug diversion (illegal distribution or abuse of prescription drug). 2. Ensure that the refrigerator emergency kit (e-Kit, a collection of medications that can help people survive or respond to an emergency) in two of two medication storage rooms investigated (subacute unit two and subacute unit three medication rooms), were replaced within 72 hours after removing three residents' medications (Resident 4, Resident 27, Resident 14) This deficient practice had the potential to delay the necessary pharmaceutical services to the residents in the subacute unit two and subacute unit three. Findings: 1 a. During a review of Resident 6's Patient Information Form (a page with information indicated for a resident such as facility admitted and pertinent diagnoses), the document indicated the resident was admitted to the facility on [DATE] with diagnoses that included respiratory failure (condition when the lungs cannot get enough oxygen into the blood). During a review of Resident 6' s Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 1/09/2025, the MDS indicated Resident 6 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 6 was dependent on staff for oral hygiene, toileting, dressing, and personal hygiene. During a review of Resident 6's Physician's Orders, the documents indicated the following orders: - Hydrocodone acetaminophen tablet (brand name is Norco, a narcotic pain medication) 10-325 milligrams (mg, a unit of measure), give one tablet by gastrostomy tube (G-Tube, a plastic tube inserted into the stomach to give medications for those with difficulty swallowing) every four hours as needed (PRN, or pro re nata, Latin for as needed) for severe pain 7-10, (numeric pain scale in which a resident's pain is indicated with zero being no pain and 10 for the worst pain imaginable), dated 7/24/2024. -Lorazepam (brand name Ativan, a medication given to treat anxiety [feelings of uneasiness]) 0.5 mg, give 0. 25 mg via G-Tube every eight hours as needed for anxiety, manifested by pulling out tubes and crying, dated 1/01/2025. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 6's CDR, the document indicated the medication Norco was removed from the blister pack (or called bubble pack, a card that packages doses of medication within small, clear, plastic bubbles [or blisters] that is punched out to administer to a resident) on the following dates: 1/28/2025 at 4:20 a.m. 1/26/2025 at 6 a.m. 1/24/2025 at 6 a.m. 1/23/2025 at 11 p.m. During a review of Resident 6's CDR, the document indicated the medication lorazepam was removed from the blister pack on the following dates: 1/24/2025 at 3 a.m. 1/23/2025 at 9 p.m. During a review of Resident 6's Medication Administration Record (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for the month of 1/2025, the MAR did not indicate Resident 6 was given Norco or lorazepam on the above dates. 1 b. During a review of Resident 42's Patient Information Form, the document indicated the resident was admitted to the facility on [DATE] with diagnoses that included acute respiratory failure with hypoxia (a serious condition that occurs when the lungs are unable to exchange oxygen and carbon dioxide [a by-product of respiration] efficiently with the blood). During a review of Resident 42's MDS, dated [DATE], the MDS indicated Resident 42 was cognitively intact with skills required for daily decision making. The MDS indicated Resident 42 required setup or clean-up assistance (helper sets up or cleans up) with eating and oral hygiene. The MDS indicated Resident 42 had a diagnosis of pain. During a review of Resident 42's Physician's Orders, the documents indicated the following orders: - Norco 5-325 mg, give one tablet by mouth every eight hours as needed for severe pain 7-10, dated 5/19/2023. During a review of Resident 42's CDR, the CDR indicated the medication Norco was removed from the blister pack on 1/24/2025 at 9 p.m.During a review of Resident 42's MAR for the month of 1/2025, the MAR did not indicate Resident 42 was given Norco on 1/24/2025 at 9 p.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a medication cart observation and concurrent record review with Registered Nurse 1 (RN 1) on 1/28/2025 at 9:08 a.m., observed the contents of Subacute 2 Medication cart 3. Reviewed Resident 6's CDR for Norco which indicated Norco was signed out to be given to Resident 6 on 1/28/2025 at 4:20 a.m., 1/26/2025 at 6 a.m., 1/24/2025 at 6 a.m., and 1/23/2025 at 11 p.m. However, there was no corresponding entry in Resident 6's 1/2025 MAR. RN 1 stated the process is that when a controlled drug is removed from the bubble pack, the licensed nurse is to sign the controlled drug record, give the medication to the resident, and then sign the MAR. RN 1 stated the licensed nurse should have signed the MAR after giving the medication. RN 1 stated this process is important so that a resident's physician knows how much medication is being given and will indicate whether a resident's pain relief is achieved. Reviewed Resident 6's CDR for Ativan which indicated Ativan was signed out to be given to Resident 6 on 1/24/2025 at 3 a.m. and 1/23/2025 at 9 p.m. However, there was no corresponding entry in Resident 6's 1/2025 MAR. Reviewed Resident 42's CDR for Norco which indicated Norco was signed out to be given to Resident 42 on 1/24/2025 at 9 p.m. However, there was no corresponding entry in Resident 42's 1/2025 MAR. During an interview with the Director of Staff Development (DSD) on 1/29/2025 2:45 p.m., the DSD stated the licensed nurse who signed the CDR but not the MAR for Resident 6 and Resident 42 worked the 7 p.m. to 7 a.m. shift. Asked for name and contact information for the licensed nurse but did not receive during the recertification survey. During an interview with the DSD on 1/30/2025 at 12:20 p.m., the DSD stated the process is that when a controlled drug is removed from the bubble pack, the licensed nurse is to sign the controlled drug record, give the medication to the resident, and then sign the MAR. The DSD stated this was important to know if the pain medication was effective, and if not affective to notify the doctor to receive an order to modify the dosage. During an interview and concurrent record review with the Director of Nursing (DON) on 1/30/2025 at 2:14 p.m., the DON stated that when a controlled drug is removed from the bubble pack, the licensed nurse is to sign the controlled drug record, give the medication to the resident, and then sign the MAR. The DON stated if there was no documentation on the MAR, then the pain was not assessed for those times. The DON stated she (DON) did not think there was an issue of drug diversion. The DON stated it is important to sign the MAR because for pain medication there is a pain level documented and if not signed on the MAR, then no assessment or reassessment of the effectiveness of the pain medication and a resident's pain relief will not be relieved. During a review of the facility's policy and procedure titled, Controlled Drug Management on Patient Care Units, reviewed 7/2024, the policy and procedure indicated when a medication is removed from stock, the narcotic drug record sheet is completed to indicated date, time, patient's name, room number, the quantity removed and the signature of a nurse administering the medication. During a review of the facility's policy and procedure titled, Controlled Medications, last reviewed 7/2024, the policy and procedure indicated the following: When a controlled medication is administered, the licensed nurse administering the medication shall immediately enter the following information on the accountability record: 1) Date and time of administration (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Amount administered 3) Signature of the nurse administering the dose, completed after the medication is actually administered Note: Entering information on the accountability record does not replace recording medication administration on the MAR. During a review of the facility's policy and procedure titled, Medication Administration, reviewed 7/2024, the policy and procedure indicated the following: The individual who administers the medication dose shall record the administration of the resident's MAR directly after the medication is given. When PRN medications are administered, the following documentation shall be provided: 1) Date and time of administration, dose, route of administration (if other than oral). 2) Complaints or symptoms for which the medication was given. 3) Results achieved from giving the dose and the time results were noted. 4) Signature of initials of person recording administration and signature or initials of person recording effects, if different from the person administering the medication. 2 a. During a review of Resident 4's Patient Information Form (a page with information indicated for a resident such as facility admitted and pertinent diagnoses), the document indicated the resident was admitted to the facility on [DATE] with diagnoses that included respiratory failure (condition when the lungs cannot get enough oxygen into the blood). During a review of Resident 4' s Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 12/18/2024, the MDS indicated Resident 4 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 6 was dependent on staff for oral hygiene, toileting, dressing, and personal hygiene. The MDS indicated Resident 4 had a diagnosis for seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a review of Resident 4's Physician's Orders, the documents indicated an order for Ativan injection solution (a medication given to treat seizures) 2 milligrams/milliliter (mg/ml, metric unit of measurement, used for medication dosage and/or amount), inject 1 ml intramuscularly (administered into the muscle through a needle) every six hours as needed for seizures, dated 1/14/2025. During a review of Resident 4's Nursing Progress Notes, dated 1/14/2025, indicated Ativan 1 mg was given for a seizure episode. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 4's Medication Administration Record (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 1/2025 indicated Resident 4 received Ativan 1 mg intramuscularly for one dose on 1/14/2025. 2 b. During a review of Resident 27's Patient Information Form, the document indicated the resident was admitted to the facility on [DATE] with diagnoses that included acute respiratory failure (condition when the lungs cannot get enough oxygen into the blood). During a review of Resident 27' s Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 1/16/2024, the MDS indicated Resident 27 was severely impaired in cognition with skills required for daily decision making. The MDS indicated Resident 27 was dependent on staff for oral hygiene, toileting, dressing, and personal hygiene. The MDS indicated Resident 4 had a diagnosis for seizure. During a review of Resident 27's Physician's Orders, the documents indicated an order for Ativan injection solution 1 mg, give intramuscularly for one dose for seizures, dated 12/24/2025. During a review of Resident 27's Nursing Progress Notes, dated 12/24/2024, indicated Ativan 1 mg was given for a seizure episode. During a review of Resident 27's MAR for 12/2024 indicated Resident 27 received Ativan 1 mg intramuscularly for one dose on 12/24/2024. During a concurrent record review and medication storage observation for the Subacute 2 Medication Room, with Registered Nurse 1 (RN 1) observed the e-Kit stored in the refrigerator, that contained one vial (a small container, typically cylindrical and made of glass, used for holding liquid medicine) of Ativan. Observed two emergency drug [NAME] Forms, one for Resident 4, dated 1/14/2025 and another for Resident 27, dated 12/24/2024. RN 1 stated these forms were filled out when medication was removed from the e-kit. Reviewed the e-Kit Content List indicated the e-Kit was originally stocked with three Ativan 2mg/ml vials. RN 1 stated the e-Kit was opened on 12/24/2024 and 1/14/2025 and that a vial of Ativan was removed each time. When asked when the pharmacy should be notified so that the e-Kit can be replaced, RN 1 stated that is to be conducted immediately right after removing the medication from the e-Kit. RN 1 stated this was important to ensure medications are replaced so there will be available for other residents who need the medications. RN 1 stated Licensed Vocational Nurse 3 (LVN 3) was the licensed nurse who removed both vials of Ativan on 12/24/2024 and 1/14/2025. During an interview with RN 1 on 1/29/2025 at 10 a.m., RN 1 stated the licensed nurse peels off a sticker when removing the medication from the e-Kit and faxes and then calls the pharmacy to come replace the e-Kit. During an interview with the Director of Staff Development (DSD) on 1/30/25 at 12:20 p.m., the DSD stated the importance of replacing the e-Kit within 72 hours is to ensure a medication is available in case of emergency. The DSD stated the process to follow is once a medication is removed from the e-Kit, the licensed nurse is to call the pharmacy to replace the e-Kit and fax the sticker to the pharmacy. After that, the pharmacy has the responsibility to replace the e-Kit. The DSD stated they were not sure what part of the process was not followed. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nurse (DON) on 1/30/25 at 2:14 p.m. the DON stated it is important to replace an e-Kit within 72 hours, is to ensure needed medications will be available to residents that need them. During a review of the facility's policy and procedure titled, Emergency Pharmacy Services/Emergency Kits, last reviewed 7/2024, indicated the following: When an emergency or starter dose (first dose) of a medication is needed, the nurse shall break the container seal and remove the required medication. As soon as possible, the nurse records the medication use on the medication order form and calls the pharmacy for replacement of the kit. When the replacement kit arrives, the receiving nurse gives the used kit to the pharmacy personnel for return to the pharmacy. All kits must be replaced within 72 hours of opening. 47883 2 c. During a review of Resident 14's Inpatient Information Form, the Inpatient Information Form indicated that the facility admitted Resident 14 on 4/20/2024 and readmitted the resident on 1/15/2025. During a review of Resident 14's care plan dated 12/11/2025, the care plan indicated the resident was admitted with diagnoses including seizures disorder (a burst of uncontrolled electrical activity between brain cells that caused temporary abnormalities in muscle tone or movements) and cerebral anoxia (a condition that affects muscle coordination and can cause clumsy movements). The care plan indicated that Resident 14 was Ativan (medication to treat seizure disorder) PRN (as needed). During a review of Resident 14 physician order dated 4/30/2024, the physician order indicated an order for Ativan 2 mg intramuscularly every 6 hours as needed for seizures. During a review of Resident 14's MDS, dated [DATE], the MDS indicated that the resident had severely impaired cognition. The MDS further indicated that Resident 14 was totally dependent on staff or required maximal assistance with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a concurrent observation and interview on 1/28/2025 at 03:53 p.m., the surveyor observed the contents of third floor medication refrigerator with Registered Nurse 2 (RN 2). The refrigerator e-Kit was open and was missing one vial of Ativan 2 mg /ml. RN 2 confirmed that emergency kit was open and missing medication. RN 2 stated that by facility policy the nurse who used medication in emergency kit has to immediately call the pharmacy and request a new emergency medication kit. RN 2 called the pharmacy and ordered the new emergency kit. RN 2 was unable to find the log for usage of emergency medication and was not sure what date it was used and for which resident. During a concurrent interview and record review on 1/29/2025 at 12p.m. with Director of Staff Development (DSD), the DSD reviewed emergency drug billing form dated 1/10/2025 and stated that Ativan 2 mg /ml was used on 1/10/2025 for Resident 14 for seizure activities. The DSD stated that that emergency kit should be replaced with 72 hours of opening. The DSD stated it is the charge nurse responsibility before reporting of duty, the charge nurse should indicate the open status of the emergency kit at the shift change if the supply has not yet been replaced by the pharmacy. The potential of this deficient practice can delay pharmaceutical services to the residents. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility policy called Emergency pharmacy services /emergency kit, last reviewed 7/2024, the policy indicated:' An emergency supply of medications, including emergency drugs, antibiotics, controlled substances, and infusion products shall be supplied by Alliance Pharmacy, Inc in limited quantities in portable, sealed containers, in compliance with all applicable state regulations .All kits must be replaced within 72 hours of opening.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34659 Based on interview and record review, the facility failed to ensure the Medication Regimen Review (MRR - review of a resident's drug therapy to assure appropriateness of medication usage completed each month by the consultant pharmacist) was acted upon for two of five sampled residents (Resident 17 and 35) by: 1. Failing to act upon the facility consultant pharmacist's recommendation to assess the need for the medication, FeroSul (also known as ferrous sulfate, medication given for those with an iron [a mineral that the body needs for growth, development, and transporting oxygen] deficiency) for Resident 17. 2. Failing to act upon the facility consultant pharmacist's recommendation to order blood testing for the medication, levetiracetam solution (Keppra [brand name], medication that treats seizures) for Resident 35. These deficient practices placed the residents at an increased risk of experiencing adverse side effects (unwanted undesirable effects that are possibly related to a drug). Findings: a. During a review of Resident 17's Patient Information Form, the Patient Information Form indicated the facility admitted the resident on 4/3/2021, with diagnoses that included respiratory failure (condition when the lungs cannot get enough oxygen into the blood). During a review of Resident 17's Minimum Data Set (MDS, a resident assessment tool), dated 11/7/2024, the MDS indicated Resident 17 was cognitively (the process of acquiring knowledge and understanding through thought, experience, and the senses) intact with skills required for daily decision making. The MDS indicated Resident 17 was dependent on staff for oral hygiene, toileting, dressing, and personal hygiene. During a review of Resident 17's physician's orders, the physician's orders indicated an order for Ferosul give 325 milligrams (mg, a unit of measurement) by mouth two times a day for supplement, dated 4/3/2021. During a review of Resident 17's MRR, dated 10/13/2024, the MRR indicated the following: Resident 17 has been receiving Ferosul tablet since 4/2021. Please consider reassessing the need for this therapy currently. There was no indication Resident 17's physician had addressed the concern on the MRR. During a concurrent interview and record review on 1/29/2025 at 3:44 p.m., with Registered Nurse 1 (RN 1), reviewed Resident 17's MRR dated 10/13/2024. RN 1 was unable to find documentation that the physician had been contacted to see if the physician wanted to continue the medication. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/30/2025 at 12:20 p.m., with the Director of Staff Development (DSD), the DSD stated the process is the consultant pharmacist sends a monthly report, and it is given to the licensed nurses to call a resident's physician. The DSD stated the licensed nurses are calling to see if the physician wants to continue, discontinue, or change a medication's dosage. The DSD stated he did not see documentation that Resident 17's use of Ferosul had been brought to the physician's attention. The DSD stated Resident 17's physician will be contacted to see if the physician wants to continue the medication, Ferosul. The DSD stated there is no policy for the nursing process of addressing the monthly MRR or the time frame required in which to address issues brought up in the report. The DSD stated it is important to address all issues reported in the MRR to ensure there is no endangerment to a resident by continuing an unnecessary medication. During an interview on 1/30/2025 at 2:14 p.m., with the Director of Nursing (DON), the DON stated the importance of addressing concerns brought up in the MRR is to ensure the necessity of a medication. The DON stated he was not sure why Resident 17's Ferosul was not addressed. The DON stated the issue should have been brought to Resident 17's physician's attention. 47883 b. During a review of Resident 35's Inpatient Information Form, the Inpatient Information Form indicated that the facility admitted Resident 35 on 7/8/2024 and readmitted the resident on 12/3/2024. During a review of Resident 35's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings), dated 7/10/2024, the H&P indicated the resident was admitted with diagnoses including chronic respiratory failure, type 2 diabetes (a long-term medical condition in which the body does not use insulin [a hormone that lowers the level of sugar in the blood] properly), and chronic encephalopathy (condition that affects the brain's function). During a review of Resident 35's MDS dated [DATE], the MDS indicated that the resident had severely impaired cognition (mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS further indicated that Resident 35 was totally dependent on staff or required maximal assistance with all activities of daily living (ADLs - activities related to personal care). During a review of Resident 35' care plan (a document that summarizes a resident's needs, goals, and care/treatment) for risk of seizures (a burst of uncontrolled electrical activity between brain cells that caused temporary abnormalities in muscle tone or movements) dated 7/23/2024, the care plan indicated Resident 35 was taking levetiracetam solution. The interventions included were to monitor for toxicity (the extent to which something is poisonous or harmful) and adverse consequences. During a review of Resident 35's physician order dated 7/8/2024, the physician order indicated an order for levetiracetam 1000 mg via gastrostomy (g-tube, a tube inserted through the abdomen to deliver nutrition and medications directly to the stomach) every 12 hours for seizures disorder. During a review of Resident 35's MRR, created between 9/1/2025 and 9/10/2025, the MRR indicated that Resident 35 was on levetiracetam, please consider ordering Keppra panel (measures the amount of levetiracetam in the blood) for clinical monitoring. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/30/2025 at 3:07 p.m., with Registered Nurse 5 (RN 5), reviewed Resident's 35 lab results from 9/1/2024 to 1/30/2025. RN 5 stated that a Keppra level test was never done for Resident 35. RN 5 stated the facility should follow the consultant pharmacist's recommendation in 30 days after recommendation was made. RN 5 stated that this deficient practice increases risk for medication side effects for Resident 35. During an interview on 1/30/2025 at 4:07 p.m., with the DON, the DON stated that facility has to follow the consultant pharmacist's recommendation about Keppra blood work to monitor Resident 35's Keppra level is in safe range. The DON stated that this deficient practice increases the risk of receiving medication that was not optimal for Resident 35's medical condition and increases the risk of adverse consequences. During a review of the facility's policy and procedure titled, Medication Administration - General Guidelines, last reviewed 7/2024, the policy indicated the following: Medications shall be administered in accordance with written orders of the attending physician. If a dose seems excessive with respect to the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnosis or condition, the nurse shall call the facility's pharmacy for clarification prior to the administration of the medication. If necessary, the facility's pharmacy shall contact the physician for clarification. This interaction with the pharmacy and the resulting order clarification shall be documented in the nursing notes and elsewhere in the medical records as appropriate. During a review of the facility's policy and procedure titled, Pharmaceutical Services Policy Procedure Manual, reviewed 11/2021, indicated, Medication orders from physician assistants, nurse practitioners, clinical nurse specialists shall be acceptable if they comply with all the requirements listed below, are in accordance the state law, and comply with applicable prescribing protocols that have been approved by the facility.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 47883 Based on interview and record review, the facility failed to monitor a resident for side effects for the use of Cymbalta (medication used for depression [mood disorder that causes a persistent feeling of sadness and loss of interest]) for one of five sampled residents (Resident 11) investigated under the care area of unnecessary medications. This deficient practice had the potential to place the resident at increased risk of taking an unnecessary medication and experiencing adverse side effects (undesired harmful effect resulting from a medication or other intervention). Findings: During a review of Resident 11's Inpatient Registration Form, the Inpatient Registration Form indicated the facility admitted Resident 11 on 5/4/2015 and the facility readmitted Resident 11 on 5/9/2017. During a review of Resident 11's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings) dated 7/1/2024, the H&P indicated Resident 11 was admitted with diagnosis included Guillain-Barre (GBS- a condition in which the immune system attacks the nerves), diabetes mellitus type two (2) (a long-term medical condition in which the body does not use insulin [a hormone that lowers the level of sugar in the blood] properly), and hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]). The H&P indicated Resident 11 had the capacity to understand and make decisions. During a review of Resident 11's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 11/11/2024, the document indicated the Resident 11 had an intact cognition (mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS further indicated that Resident 11 was totally dependent on staff or required maximal assistance with all activities of daily living (ADLs - activities related to personal care). During a review of Resident 11's physician's orders dated 11/21/2022, the physician's orders indicated an order for Cymbalta capsule delayed release 60 milligrams (mg- unit of measurement), give one (1) capsule by mouth. During a review of Resident 11's care plan (a document that summarizes a resident's needs, goals, and care/treatment) for Cymbalta initiated on 1/10/2025 , the care plan interventions indicated to monitor for adverse side effects every shift, tally with hashmark, monitor for tardive dyskinesia (involuntary movements of the tongue, jaw, face, mouth), monitor for cognitive impairment, monitor for akathisia (a movement disorder that cause a person to feel restless and have an uncontrollable urge to move), facial expression, drooling, rigidity (stiffness), monitor for orthostatic hypotension (a form of low blood pressure that happens when standing after sitting or lying down which can cause dizziness or lightheadedness and possibly fainting). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/29/2025 at 10:22 a.m., with Registered Nurse 4 (RN 4), reviewed Resident 11's Medication Administration Record (MAR - a report detailing the drugs administered to a resident by a healthcare professional) dated 1/2025. RN 4 stated Resident 11 received Cymbalta 60 mg by mouth on the following dates and times: 1.1/17/2025 at 9 a.m. 2.1/18/2025 at 9 a.m. 3.1/19/2025 at 9 a.m. 4.1/20/2025 at 9 a.m. 5.1/21/2025 at 9 a.m. 6.1/22/2025 at 9 a.m. 7. 1/23/2025 at 9 a.m. 8. 1/24/2025 at 9 a.m. 9. 1/25/2025 at 9 a.m. 10.1/26/2025 at 9 a.m. 11 1/27/2025 at 9 a.m. When asked to provide documentation that the licensed nurses were monitoring for side effects, RN 4 stated she could not find any documentation indicating that the nurses were monitoring for side effects. During an interview on 1/29/2025 at 12 p.m., with the Director of Staff Development (DSD), the DSD stated nurses needed to monitor for adverse side effects so it could be reported to the physician and necessary changes could be made to the dosage. The DSD stated if the nurses did not monitor for side effects then the resident may possibly be receiving an unnecessary medication. During a review of the facility's policy and procedure titled, Psychoactive Drug Monitoring, last reviewed and revised on 3/2024, the policy indicated physician, nurse, or other health professional documentation that the resident is being monitored for adverse consequences or complications of therapy.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47883 Based on observation, interview, and record review, the facility failed to ensure safe provision of pharmaceutical services in accordance with professional standards by failing to: 1. Ensure an open (in-use) potassium chloride (supplement used for treatment of hypokalemia [lower than normal potassium level]) solution was labeled with an open date to readily identify the beyond use date for one of one sampled resident (Resident 44). 2. Discard an open and discontinued chlorhexidine 0.12% (antiseptic [slows or stops growth of microorganisms] used to treat skin infection), solution stored in the medication cart for one of one sampled resident (Resident 54). 3. Ensure a container of Vitamin A and Vitamin D (a medication used as a moisturizer to treat or prevent dry, rough, scaly, itchy skin and minor skin irritations, known simply as A & D Ointment) Skin Ointment was labeled upon opening for one of four medication carts (Medication Cart B) investigated for medication storage. These deficient practices had the potential for the unintentional administration of possibly expired or discontinued medications. Findings: 1. During a review of Resident 44's Inpatient Registration Form, the Inpatient Registration Form indicated that the facility admitted Resident 44 on [DATE] and readmitted the resident on [DATE]. During a review of Resident 44's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings) dated [DATE], the H&P indicated the resident was admitted with diagnoses including intraparenchymal hematoma of brain (bleeding within the brain tissue) and dysphagia (difficulty swallowing). During a review of Resident 44's Minimum Data Set (MDS, a resident assessment tool), dated [DATE], the MDS indicated Resident 44 had severely impaired cognition (mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS further indicated that Resident 44 was totally dependent on staff with all activities of daily living (ADLs - activities related to personal care). During a review of Resident 44's physician's orders, the physician's orders indicated an order for potassium chloride oral solution 10% (unit of measurement of concentration) give 15 milliliters (ml- unit of measurement) via gastrostomy (g-tube, a tube inserted through the abdomen to deliver nutrition and medications directly to the stomach) in the morning for supplement dilute with 20 ml of water, dated [DATE]. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on [DATE] at 3:53 p.m., with Registered Nurse 2 (RN 2), observed the contents of Medication Cart A. Observed an opened potassium chloride oral solution 10% with no open date and no beyond used date. RN 2 confirmed by stating that the potassium chloride oral solution 10% did not have the date when it was opened. RN 2 stated that the potassium chloride oral solution 10% should have the date when it was opened to readily identify its beyond use date. 2. During a review of Resident 54's Inpatient Registration Form, the Inpatient Registration Form indicated that the facility admitted Resident 54 on [DATE] and readmitted the resident on [DATE]. During a review of Resident 54's H&P dated [DATE], the H&P indicated the resident was admitted with diagnoses including chronic respiratory failure (condition in which not enough oxygen passes from your lungs into your blood), atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate), and dysphagia. During a review of Resident 54's MDS dated [DATE], the MDS indicated Resident 4 had severely impaired cognition. The MDS further indicated that Resident 44 was totally dependent on staff with all ADLS. During a review of Resident 54's physician's orders, the physician's orders indicated there was no order for chlorohexidine oral solution 0.12%. During a review of Resident 54's Medication Administration Record (MAR - a report detailing the drugs administered to a resident by a healthcare professional), dated ,d+[DATE], the MAR indicated that Resident 54 did not receive chlorohexidine oral solution. During a concurrent observation and interview on [DATE] at 3:53 p.m., with RN 2, observed the contents of Medication Cart A. Observed an open chlorohexidine oral solution 0.12% with no open date and no beyond used date for Resident 54. RN 2 confirmed by stating that chlorohexidine oral solution 0.12% did not have the date when it was opened. RN 2 stated that the chlorohexidine oral solution 0.12% should be discarded because there was no physician order for this medication for ,d+[DATE] and Resident 54 was not taking it. During an interview on [DATE] at 4:13 p.m., with the Director of Staff Development (DSD), the DSD stated medications with no order should be removed from the medication cart. The DSD stated the staff are to call the pharmacy to come and take the medication from the medication cart. The DSD stated this should be done the day the medication was discontinued or by the next day if the pharmacy is not available the day of the order discontinuation. The DSD stated this was important to avoid possible medication error such as a resident accidentally receiving the unordered medication. The DSD stated it is important for medications to be labeled with open date because there was a potential for a resident to receive an ineffective medication. During a review of the facility's policy and procedure titled, Storage of Medication last reviewed and revised on ,d+[DATE], the policy and procedure indicated, Medications and biologicals shall be stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier .Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures shall be immediately removed from stock, disposed of according to procedures for medication disposal. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	34659 3. During a concurrent observation and interview on [DATE] at 9:50 a.m. with Registered Nurse 1 (RN 1), observed Medication Cart B. Observed an open, undated Vitamin A and Vitamin D Skin Ointment in the bottom drawer. RN 1 stated all medications that are opened must have an open date on it so that the licensed nurses will know how long it has been opened to not keep the medication for too long of a time. During an interview on [DATE] at 12:20 p.m., with the DSD, the DSD stated medications in the medication carts need to be dated with the date it was first opened. The DSD stated A & D Ointment is considered a medication and was unsure of the shelf life (the length of time for which an item remains usable) after opening of the container. During a review of the facility's policy and procedure titled, House-Supplied Floor Stock (bulk medications placed in the drug room or medication cart of the nursing unit enabling licensed nurses to access the medicines faster without going through an in-patient pharmacy) Medications, last reviewed ,d+[DATE], the policy indicated the following: Floor stock may not be maintained on the nursing unit beyond the manufacturer's expiration date. Once the medication has expired or has been opened for more than 180 days, it must be removed and sequestered from all other floor stock until it can be destroyed).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44309 Based on observation, interview, and record review, the facility failed to ensure proper food storage practices by failing to ensure food stored in the facility's freezers were labeled with the date they were placed in the freezer. This deficient practice had the potential to place 17 out of 58 residents who receive food from the facility's kitchen at risk for foodborne illnesses (refers to illness caused by the ingestion of contaminated food or beverages). Findings: During a concurrent observation and interview on 1/27/2025 at 8:10 a.m., in the facility's kitchen with Registered Dietician 1 (RD 1), observed an unlabeled plastic bag containing five individually sealed frozen pork chops in Freezer 1. RD 1 stated all food items in the freezer are required to be labeled with the date they were placed in the freezer. During a concurrent observation and interview on 1/27/2025 at 8:13 a.m., in the facility's kitchen with RD 1, observed an unlabeled bag of frozen fish sticks in Freezer 2. RD 1 stated all food items in the freezer are required to be labeled with the date they were placed in the freezer. During an interview on 1/27/2025 at 2:45 p.m., with the Dietary Supervisor (DS), the DS stated all food in the freezer needs to be labeled with the date they were placed in the freezer. During a review of the facility's policy and procedure (P&P) titled, Food and Nutrition Services, last reviewed 3/2021, the P&P indicated that frozen foods will be wrapped or containerized in a manner that prevents oxidation (freezer-burn). Single or separate food items taken out of the original container will be labeled with the name of the item and date of delivery for easy identification.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 38469 Based on interview and record review, the facility failed to electronically submit staffing information based on payroll data on a quarterly schedule to the Centers of Medicare and Medicaid Services [CMS, a federal government agency that manages the Medicare and Medicaid programs, which provide health coverage to millions of Americans]) for two of four fiscal quarters (3rd quarter [April 1 to June 30, 2024] and 4th quarter of 2024 [July1- September 30, 2024]. The deficient practice prevented the provision of complete and accurate direct care staffing information to the public. Findings: During a concurrent interview and record review on 1/30/2025 at 11:25 a.m., with the Director of Staff Development (DSD), reviewed the Payroll-Based Journal Staffing Data Report (PBJ-SDR) for 3rd and 4th quarter of 2024. The DSD stated that the person in-charge now of submitting the PBJ-SDR is on medical leave and he has no idea if she had submitted the data for these particular reporting period on or before the due date. The DSD also stated that the previous facility Administrator and the Director of Nursing (DON) were the ones who have access to the PBJ-SDR reporting portal and are no longer employed by the facility and that could be the reason that there was no submission for the reporting periods for the 3rd and 4th quarter of 2024. During a review of the facility-provided policy titled, PBJ Data Submission Specifications, dated 4/16/2020, the policy indicated that staffing and census information will be reported electronically to CMS through the Payroll-Based Journal system in compliance with 6106 of the Affordable Care Act. Staffing information is collected daily and for each fiscal quarter no later than 45 days after the end of the reporting quarter. Dates are as follows: Fiscal Quarter 1: October 1- December 31. Submission deadline: February 14 Fiscal Quarter 2: January 1-March 31. Submission deadline: May 15 Fiscal Quarter 3: April 1- June 30. Submission deadline: August 14 Fiscal Quarter 4: July 1- September 30. Submission deadline: November 14

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on observation, interview, and record review, the facility failed to maintain infection control practices by failing to: 1. Ensure Housekeeping 1 (HK 1) donned (to wear) a gown before entering a room under contact isolation (used when a resident has an infectious disease that may be spread by touching either the resident or other objects the resident has handled) and performed hand hygiene after exiting the resident's room for one of one sampled resident (Resident 38). 2. Ensure Licensed Vocational Nurse 1 (LVN 1) donned a protective gown while administering medication via gastrostomy tube (G- Tube, a tube inserted through the belly that brings nutrition and medication directly to the stomach) to a resident on enhanced barrier precautions (EBP - a set of infection control practices that use personal protective equipment [PPE - equipment worn to reduce exposure to hazards in the workplace] to reduce the spread of multidrug-resistant organisms [MDROs - microorganisms that are resistant to multiple classes of antibiotics and antifungals] in nursing homes) for one of five sampled residents (Resident 7). 3. Ensure Licensed Vocational Nurse 6 (LVN 6) donned a gown during bolus feeding (a method of administering liquid nutrition) and medication administration via g-tube to a resident on EBP for one of five sampled residents (Resident 8). This deficient practice had the potential to result in the spread and development of infection through possible cross-contamination (the physical movement or transfer of harmful bacteria from one person, object, or place to another). Findings: 1. During a review of Resident 38's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings) dated 6/25/2024, the H&P indicated that the facility originally admitted the resident on 5/23/2022 and readmitted the resident on 6/25/2024, with diagnoses including hemorrhagic stroke (a life-threatening emergency that happens when a blood vessel in your brain breaks and bleeds), tracheostomy (an opening surgically created through the neck into the windpipe to allow air to fill the lungs), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and recurrent urinary tract infection (UTI- an infection in the bladder/urinary tract). During a review of Resident 38's Minimum Data Set (MDS - a resident assessment tool) dated 11/26/2024, the MDS indicated that the resident was at persistent vegetative state (a chronic disorder in which an individual with severe brain damage appears to be awake but shows no evidence of awareness of their surroundings). The MDS indicated that Resident 2 was dependent to staff (helper does all of the effort) for oral hygiene, toileting hygiene, showering and bathing, upper and lower body dressing, putting on/talking off footwear, and personal hygiene. The MDS further indicated that Resident 38 had an indwelling catheter (a hollow tube inserted into the bladder to drain or collect urine). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 38's Medication Review Report (physician order) dated 12/23/2024, the Medication Review Report indicated to place the resident on contact isolation for Carbapenem-resistant Enterobacterales (CRE-a type of bacteria that can cause serious infections and can be hard to treat)/Extended-Spectrum Beta-Lactamases (ESBL- enzymes [proteins that help speed up metabolism] produced by some bacteria that may make them resistant to some antibiotics) of urine. During a concurrent observation and interview on 1/27/2025 at 9:42 a.m., with Licensed Vocational Nurse 4 (LVN 4), Housekeeper 1 (HK 1) was observed entering Resident 38's room, which had a contact isolation sign posted on the door, without wearing a gown. HK 1 collected the trash, exited Resident 38's room, took off his (HK 1) gloves, and placed the trash bag inside the trash bin and left without performing hand hygiene. LVN 4 stated all staff entering Resident 38's room are required to wear gloves and gown, because Resident 38 is on contact isolation. LVN 4 stated HK 1 could potentially spread the infection when entering other residents' rooms. LVN 4 stated HK 1 exited Resident 38's room and removed his gloves without performing hand hygiene. LVN 4 stated staff are required to wash their hands or use alcohol-based hand sanitizer (ABHS) after exiting each resident's rooms. LVN 4 stated the potential outcome of not performing hand hygiene after exiting a resident room and in between residents is spreading infection to other residents and staff members. During an interview on 1/28/2025 at 8:41 a.m., with the Housekeeping Lead (HKL), the HKL stated the facility's Infection Preventionist (IP) gives in-services regarding infection control to all housekeeping staff. The HKL stated staff are required to wear a gown when entering a resident's room that has a contact precaution sign posted. The HKL stated staff are required to perform hand hygiene after exiting each resident's room, especially a resident under contact precaution. The HKL stated the potential outcome of not donning a gown when entering a resident's room with contact isolation and not performing hang hygiene after exiting, is the spread of infection to other residents and facility staff. During a review of the facility's policy and procedure (P&P) titled, Isolation Precautions-Contact Precautions, last reviewed 11/2023, the P&P indicated in addition to wearing gloves as outlined under standard precautions, wear a gown when entering the room if you anticipate that your clothing with have substantial contact with the patient, environment surfaces, or items in the patient's room. After gown removal ensure that clothing does not contact potentially contaminated environment surfaces to avoid transfer of microorganisms to other patients or the environment. During a review of the facility's P&P titled Isolation Precautions-Standard Precautions, last reviewed 11/2023, the P&P indicated to wash hands after touching blood, body fluids, secretions, excretions and contaminated items, whether or not gloves are worn. Wash hands immediately after gloves are removed, between patient contacts and when otherwise indicated to avoid transfer of microorganisms to other patients or the environment. 38469 2. During a review of Resident 7's Patient Information, the Patient Information indicated the facility originally admitted the resident on 1/21/2024 and readmitted the resident on 1/29/2024, with diagnoses including chronic respiratory failure (condition in which not enough oxygen passes from your lungs into your blood) and persistent vegetative state. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 7's MDS dated [DATE], the MDS indicated Resident 7 is in a persistent vegetative state. The MDS indicated that Resident 7 was totally dependent on staff for self-care. During a review of the facility's posted signage in Resident 7's room, the signage indicated the following, Enhance Barrier Precautions: Everyone must, clean their hands, including before entering and leaving the room. Provider and Staff must also: Wear gloves and gown for the following High-Contact Resident Care Activities .Device care or use: central line (long, thin, flexible tube that's inserted into a large vein near the heart), urinary catheter, feeding tube, tracheostomy (an opening created at the front of the neck so a tube can be inserted into the windpipe [trachea] to help you breathe) . During a concurrent medication observation and interview on 1/28/2025 at 4:18 p.m., observed Licensed Vocational Nurse 1 (LVN 1) administer tramadol (medication used for moderate to severe pain) 50 milligrams (mg- unit of measurement) to Resident 7 via g-tube. During the entire process of administering the medication, LVN 1 was not wearing a protective gown. After the medication administration, LVN 1 stated that he should have worn a protective gown when administering medication to a resident on enhance barrier precaution for infection control. LVN 1 stated that wearing a protective gown can prevent Resident 7 from acquiring infection due to cross contamination, as staff's clothing can be contaminated when taking care of multiple residents which can result to Resident 7 becoming ill. During a review of the facility's P&P titled, Isolation Precautions, last reviewed on 11/2023, the P&P indicated in the implementation of Enhanced Standard Precaution to perform hand hygiene and don PPE, gloves to protect hands, gown to protect body and clothes . 47883 3. During a review of Resident 8's Inpatient Information Form, the Inpatient Information Form indicated that the facility admitted Resident 8 on 1/25/2013. During a review of Resident 8's H&P dated 3/15/2024, the H&P indicated the resident was admitted with diagnoses including chronic respiratory failure, gastroparesis (a condition that affects the stomach muscles and prevents proper stomach emptying), and hemiplegia and hemiparesis (weakness or paralysis of one side of the body). During a review of Resident 8's MDS dated [DATE], the MDS indicated that the resident had moderately impaired cognition (thought processes). The MDS further indicated that Resident 8 was totally dependent on staff or required maximal assistance with all activities of daily living (ADLs - activities related to personal care). During a review of Resident 8's Order Summary Report, the Order Summary Report indicated an order dated 4/21/2020 for enteral feed every four (4) hours of bolus (administration of a discrete amount of medication, drug, or other compound within a specific time) of Jevity 1.2 calories (feeding formula) of six (6) cans a day. During a review of Resident 8's care plan (a document that summarizes a resident's needs, goals, and care/treatment), dated 1/29/2025 regarding EBP, an intervention included for staff to wear gloves and gown during high-contact care activities. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a medication administration observation on 1/29/2025 at 8:12 a.m. in Resident 8's room, observed Resident 8's wall had signage which indicated that the resident was on EBP, which required to don a gown and gloves when performing high contact activity and use of feeding tube. Observed LVN 6 administering enteral feeding bolus of two (2) cans of Jevity 1.2 calories and medications via g-tube without wearing a gown. During an interview on 1/29/2025 at 8:25 a.m., with LVN 6, LVN 6 stated that she (LVN 6) did not wear a gown during Resident 8's enteral feeding administration of Jevity 1.2 calories. LVN 6 stated that she was not aware that she has to wear a gown when using a g-tube to administer bolus feeding or medication to Resident 8 to prevent possible infection spread. During an interview on 1/29/2025 at 12 p.m., with the Director of Staff Development (DSD), the DSD stated that residents placed on EBP include residents at increased risk of developing an infection because they have a g-tube. The DSD stated when a resident is on EBP, all staff are required to don gowns and gloves when performing high contact resident care activities (activities that have been demonstrated to result in the transfer of MDROs to hands or clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated) such as administering bolus feeding and medication via g-tube. During an interview on 1/30/2025 at 7:43 a.m., with the Infection Preventionist (IP), the IP stated that according to the facility's policies regarding EBP, LVN 6 should have donned a gown prior to administering bolus feeding and medication via g-Tube to Resident 8. During a review of the facility's P&P titled, Isolation Precautions, last reviewed on 11/2023, the P&P indicated in the implementation of Enhanced Standard Precaution to perform hand hygiene and don PPE, gloves to protect hands, gown to protect body and clothes .