STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555256	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rehabilitation Center of Bakersfield	2211 Mount Vernon Avenue Bakersfield, CA 93306

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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. 42744 Based on observation, interview, and record review, the facility failed to ensure an adaptive call light (specially designed call button for individuals with physical disabilities or limited mobility to easily signal for assistance) was provided for one of one sampled dependent resident (Resident 80). This failure resulted in unmet needs due to being unable to call staff. Findings: During a concurrent observation and interview on 1/6/25 at 9:30 a.m. with Resident 80 in Resident 80's room, the call light was wrapped around the right upper side rail. Resident 80 had contractures in his right hand and his left arm was limp. Resident 80 stated he did not have the coordination to use the call light and he whistled to call staff for assistance. During a concurrent observation and interview on 1/7/25 at 1:56 p.m. with Certified Nursing Assistant (CNA) 2 in Resident 80's room, Resident 80's call light was observed tied to the right upper side rail. CNA 2 stated Resident 80 would not be able to use this call light. During an interview on 1/9/25 at 9:35 a.m. with Director of Nursing (DON), DON stated all residents should have call lights they can use when they need assistance. DON stated the facility had call lights shaped like little houses that were easy for dependent residents to press when they needed assistance. DON stated Resident 80 should have had one of house shaped call lights. During a review of the facility's policy and procedure (P&P) titled, Communication - Call Systems, dated 1/1/12, the P&P indicated, Policy The facility will provide a call system to enable residents to alert the nursing staff from their rooms and toileting/bathing facilities. Procedure . VIII. Adaptive call bell provided to resident per resident's needs.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42744 Based on interview and record review, the facility failed to follow their policy and procedure (P&P) titled, Personal Property for one of one sampled resident (Resident 13) when Inventory of Personal Effects (IPE) form was not reviewed for accuracy during Resident 13's quarterly care plan conference. This failure resulted in incorrectness of Resident 13's IPE based on her current personal belongings, the inability to verify missing items, and the potential of those missing items not being replaced because they are not on the IPE. Findings: During an interview on 01/07/25 at 01:21 p.m. with Resident 13, Resident 13 stated she had personal belongings missing, including a gold box shaped like an egg that she had received at Christmas. Resident 13 stated she had reported the missing items and she did not see facility staff making an effort to find them. During a review of Resident 13's IPE, dated 7/30/23, the IPE indicated the last review and update of Resident 13's personal effects was on 7/23/23. The IPE indicated Resident 13 had a white fan, mattress, 32 inch television, and a dresser. The IPE indicated Resident 13 had no other personal belongings. During an interview on 1/9/25 at 3:05 p.m. with Social Services Assistant (SSA), SSA stated when a resident loses something a theft and loss report is filled out, then staff look for the missing item. SSA stated to replace the missing item, it should be on the IPE. SSA stated if the missing item is not on the IPE, then the facility is not obligated to replace it. SSA stated sometimes the Administrator will replace it anyway. During a concurrent interview and record review on 1/9/25 at 3:26 p.m. with SSA, Resident 13's Multidisciplinary Care Conference, (MCC) dated 10/22/24, was reviewed. The MCC indicated Resident 13 was admitted on [DATE]. The MCC indicated during Resident 13's quarterly care plan conference dated 10/22/24 the IPE was not reviewed for accuracy. SSA stated the IPE was not discussed or updated to reflect Resident 13's current belongings. SSA stated based on the facilities P&P, the facility should have reviewed and updated Resident 13's IPC at the time of the MCC quarterly review. During a review of the facility's P&P titled, Personal Property, dated 7/14/17, the P&P indicated, Procedure V. The IDT [Interdisciplinary Team - group of health care professionals that address the whole person, not just specific medical aspects] will review the resident's inventory for accuracy during the resident's quarterly care plan conference. Any changes or additions to the inventory will be made at this time.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 39763 Based on interview and record review, the facility failed to ensure the facilities grievance process was followed for one of three sampled residents (Resident 16). This failure had the potential for Resident 16 to be subject to continued abuse and resulted in Resident 16 being unaware of the plan of correction or outcome of the grievance investigation. Findings: During an interview on 12/30/24 at 2:39 p.m. with Resident 16, Resident 16 stated he filed a grievance with Social Service Assistant (SSA) regarding abuse allegations (12/23/24). Resident 16 stated the facility had not followed up with him regarding the grievance. During a review of Resident 16's Resident Grievance/Complaint Investigation Report,(RGCIR) dated 12/23/24, the RGCIR indicated the Resident 16's grievance report was assigned to the Administrator. The RGCIR indicated, Assigned Department's response to Grievance (includes any actions taken, investigations plan to correct: [space to indicate if completed was blank] Was the grievance confirmed (space to indicate if completed was blank) Department Head Signature dated (space was blank) Grievance Official Signature Date (space was blank) Concerned Party Notified on (space to indicate if completed was blank) By (space was blank) Concerned Party's Response (space was blank). During a concurrent interview and record review on 1/7/25 at 11:30 a.m. with Administrator, Resident 16's RGCIR, dated 12/23/24 was reviewed. Administrator stated the RGCIR was not completed and no notification was made to Resident 16 of the outcome of the investigation or plan to correct the grievance. During a review of the facility's policy and procedure (P&P) titled, Grievances and Complaints, dated December 2017, the P&P indicated, II. The facility Administrator is the Grievance Official responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusion, . B. The investigation and report includes, as applicable: . viii. Statement as to if the grievance/complaint was confirmed and corrective actions taken. C. The Grievance Official will be provided with a completed Resident Grievance/Complaint Investigation Report within five (5) business days of the start of the investigation.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 39763 Based on interview and record review, the facility failed to follow their policy and procedure (P&P) titled, Abuse Investigation and Reporting, for one of three sampled residents (Resident 115). This failure had the potential for Resident 115 and the facility's residents to be at risk for abuse. Findings: During an interview on 12/30/24 at 12:41 p.m. with Director of Nursing (DON) 2, DON 2 stated Social Services Assistant (SSA), Case Manager (CM), and herself were responsible for the investigation of the allegations of physical abuse for Resident 115 by Certified Nursing Assistant (CNA) 1. DON 2 stated she interviewed Resident 115, Resident 115's family, Resident 115's roommate and staff as part of the alleged abuse investigation. DON 2 stated she did not interview any other residents regarding the care provide by CNA 1. During an interview on 12/30/24 at 3:23 p.m. with SSA, SSA stated she was not involved in the investigation of Resident 115's allegations of physical abuse. During an interview on 12/30/24 at 3:54 p.m. with CM, CM stated she was not involved in the investigation of Resident 115's allegations of physical abuse. During an interview on 1/7/25 at 11:30 a.m. with Administrator, Administrator stated DON 2 was responsible for Resident 115's investigation. Administrator stated she was not involved in the investigation of Resident 115's allegations of physical abuse. During a review of the facility's P&P titled, Abuse Investigation and Reporting, revised December 2016, the P&P indicated, All reports of abuse . shall be . thoroughly investigated by facility management. Role of the Investigator: 1. The individual conducting the investigation will, as a minimum: . i. Interview other residents to whom the accused employee provides care or services.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 41035 Based on interview and record review, the facility failed to follow their policy and procedure (P&P) titled, Notice of Transfer/Discharge, when the facility did not send a notice of transfer to the ombudsman (advocate for residents in a long-term care facilities) for two of two sampled residents (Resident 24 and Resident 69). This failure had the potential for Resident 24 and Resident 69 to not have an advocate to review their admission, transfer, and discharge rights and options. Findings: During a concurrent interview and record review on 1/9/25 at 9:10 a.m. with Minimum Data Set Coordinator (MDSC), Resident 24's Medical Record (MR) was reviewed. MDSC stated Resident 24 was transferred to the hospital on 10/2/24. MDSC stated he was unable to provide a transfer and discharge form for Resident 25 which indicated the Ombudsman was notified. During a concurrent interview and record review on 1/9/25 at 11 a.m. with Social Services Assistant (SSA), Resident 24's MR was reviewed. SSA stated she could not find documentation that the Ombudsman was notified of Resident 24's transfer. SSA stated the Ombudsman should have been notified of the Resident 24's transfer. During a concurrent interview and record review on 1/9/25 at 9:32 a.m. with MDSC, Resident 69's MR was reviewed. MDSC stated Resident 69 was transferred to the hospital on 3/31/24. MDSC stated he was unable to provide a transfer and discharge form for Resident 69 which indicated the Ombudsman was notified. During a concurrent interview and record review on 1/9/25 at 10:47 a.m. with SSA, Resident 69's MR was reviewed. SSA stated she was unable to provide a transfer and discharge form for Resident 69 which indicated the Ombudsman was notified. During a review of the facility's P&P titled, Notice of Transfer/Discharge, dated 2017, the P&P indicated, Before the transfer or discharge occurs, the facility must notify the resident and, if known, the responsible party, and Ombudsman of the transfer and reasons for the transfer, and document in the resident's clinical record.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 50409 Based on interview and record review, the facility failed to follow their policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning for two of three sampled residents (Resident 1 and Resident 64) when 1. When a conservator (resident's legal representative) did not participate in Patient 1's care conference. This failure resulted in Resident 1's conservator to not participate in Patient 1's plan of care or be aware of changes in plan of care. 2. When a comprehensive care plan did not include individualized goals and interventions for restorative mobility for Patient 64. This failure had the potential for Patient 64 to not reach full mobility and function potential. Findings: 1. During a review of Resident 1's Admission Record (AR), dated 1/7/25, the AR indicated, Diagnosis. Dementia [a decline in mental abilities that affects thinking, memory, and reasoning]. Altered Mental Status. Cognitive Communication Deficit [unable to communicate effectively due to problems with how their brain processes information]. During a review of Resident 1's Notice to Conservatee of Rights to Probate Code, (NCRPC) dated 10/2/24, the NCRPC indicated Family Member (FM) 1 was Resident 1's conservator. During a review of Resident 1's MD Progress Note, (MPN) dated 11/8/24, the MPN indicated Resident 1 did not have capacity to understand choices and make healthcare decisions. During a review of Resident 1's Minimum Data Set, (MDS - an assessment tool) dated 11/23/24, the MDS indicated Resident 1 had a Brief Interview for Mental Status (BIMS - used to measure and track a resident's thinking abilities decline or improvements) score of 4 (score of 0 to 7 indicates severe cognitive impairment). During a concurrent interview and record review on 1/6/25 at 4:29 p.m. with Social Services Assistant (SSA), Resident 1's Multidisciplinary Care Conference, (MCC) dated 8/22/24 was reviewed. SSA stated there was no documentation FM 1 attended Resident 1's MCC conducted on 8/22/24. SSA stated a resident representative should always be present during the MCC. During a review of the facility's P&P titled, Comprehensive Person-Centered Care Planning, dated 2022, the P&P indicated, 2. Interdisciplinary Team (IDT) a. The IDT team may include but is not limited to the following individuals.To the extent possible, the resident and the resident's representative(s). An explanation must be included in a resident's medical record if participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. 42744 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a concurrent interview and record review on 1/9/24 at 12:20 p.m. with Director of Nursing (DON), Resident 64's Comprehensive Care Plan (CCP), dated 1/7/25, was reviewed. The CCP indicated Resident 64 did not have a care plan with goals or interventions for strengthening upper extremities. DON stated it looked like the care plan was started but staff did not put in the interventions. During a review of the facility's P&P titled, Comprehensive Person-Centered Care Planning, dated 2022, the P&P indicated, All goals, objectives, interventions, etc. from the current baseline care plan will be included in the resident's comprehensive care plan. During a review of the facility's P&P titled, Restorative Nursing Program Guidelines, date 9/19/19, the P&P indicated, Procedure 1. The following criteria must be met in order to implement a restorative nursing program: A. Measurable objective and interventions are documented in the Care Plan and in the medical record. If a Restorative Nursing Program is in place when a Care Plan is being revised, it is appropriated to assess progress, goals, and duration/frequency as part of the care planning process. Good clinical practice would indicate that the results of this reassessment should be documented in the resident's medical record. V. The Interdisciplinary Care Plan will reflect the written plan of care for meeting the restorative needs of each resident including problems/needs, measurable goals and individualized approaches. X. The Care Plan for each resident will be updated with any changes to the Restorative Nursing Program when they occur and reviewed quarterly or as needed by the Interdisciplinary Team.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 42344 Based on observation, interview, and record review, the facility failed to: 1. Ensure a verbal order (VO) for one of six sampled residents (Resident 116) was entered into the medical record (MR). This failure had the potential for increased risk of medication errors, potential patient harm due to incorrect treatment, and resulted in an incomplete medical record. 2. Follow their policy and procedure (P&P) titled, Medication - Administration for one of six sampled resident (Resident 45) when incorrect dose of medication was given. This failure had the potential for Resident 45 to have adverse health outcomes. Findings: 1. During a concurrent interview and record review on 1/9/25 at 2 p.m., with Licensed Vocational Nurse (LVN) 1, Resident 116's Progress Notes, (PN) dated 10/21/24 and the Orders, dated October 2024 were reviewed. The PN indicated, Resident [116] noted with limit [sic] response, pale in color and diaphoretic [sweating]. BS [blood sugar] 38, BP [blood pressure]147/67, O2 [oxygen] 90%. Glucose Gel [medication to increase the blood sugar] administered at 1715 [5:15 p.m.] . Glucogon [sic] [medication to increase the blood sugar level] 1 mg [milligram] IM [intramuscular- injected in the muscle] administered at 1745 [5:45 p.m.]. The Orders indicated no order for Glucagon. LVN 1 stated she called Resident 116's doctor and he gave her a VO to administer the Glucagon and she did not enter the VO in the MR. Did you review the MAR and there was no documentation of administration? During a review of the facility's policy and procedure (P&P) titled, Telephone Orders for Medication, revised 1/1/2012, the P&P indicated, Receiving a Telephone Order (TO).the order will be repeated back to clarify and ensure that the following necessary information is included: i. Name of Medication; ii. Dosage; iii. Route of administration; iv. Times and/or frequency of administration; v. Number of days or doses; and vi. Reason for medication as occasion requires (PRN) [as needed].III. Transcribing The Orders A. The order will be written with black ballpoint pen on Medication Administration Record or Treatment Administration Record and complete start order date. 2. During an observation on 1/7/25 at 8:59 a.m. with LVN 2 in Resident 45's room, LVN 2 administered 200 ml (Milliliters) of Med Plus 2.0 (Nutritional Shake). During a concurrent interview and record review on 1/7/25 at 2:20 p.m. with LVN 2, Resident 45's Medication Administration Record, (MAR) dated January 2025 was reviewed. The MAR indicated Med Plus 2.0 120 mls two times a day for supplement with medication. LVN 2 stated she administered 200 mls of Med Plus and the MAR indicated to administer 120 mls. During a review of the facility's P&P titled, Medication - Administration, dated 1/1/12, the P&P indicated, Medications and treatments will be administered as prescribed to ensure compliance with dose guidelines. 42744 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	48901

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 42744 Based on interview and record review, the facility failed to ensure for one of one sampled resident (Resident 64): 1. Physician's orders were followed for the Restorative Nursing Assistant (RNA) therapeutic program (program designed to help residents maintain or improve their functional abilities). This failure had the potential to result in decline of Resident 64's strength and mobility. 2. The RNA completed RNA program written weekly summaries. This failure resulted Resident 64's progress towards regaining independence in daily activities was not monitored which had the potential for a decline in function and mobility. Findings: 1. During a review of Resident 64's physician orders (PO), dated 10/22/24, the POs indicated Resident 64 was to have RNA therapy five times a week as part of the RNA program. Resident 64's RNA therapy program was to include: a. Therapy exercises using rickshaw (exerciser for wheelchair dependent people to strengthen their arms and shoulder muscles) with 20 lbs (pounds) and or alternate of pulley 4 for 2.5 plates for 15 minutes or as tolerated b. AROM (Active Range of Motion) right and left lower extremity as tolerated, every day shift c. Leg ergometer (a seated stationary pedal exerciser) for 15 minutes as tolerated every day shift. During an interview on 1/6/25 at 3:19 p.m. with Resident 64, Resident 64 stated he went to the gym with the RNA, but the RNA was frequently assigned to work as a Certified Nursing Assistant (CNA) so he missed his exercises on those days. Resident 64 stated this made it hard for him to have any continuity with his therapy. Resident 64 stated he would like to be evaluated for more physical therapy to get stronger. During a concurrent interview and record review on 1/9/25 at 11:15 a.m. with RNA, Resident 64's electronic medical record (eMR) tasks, dated 12/11/24 through 1/8/25 were reviewed. The eMR tasks indicated Resident 64 received AROM to his lower extremities and used the leg ergometer as follows: Week of 12/11/24 to 12/17/24- one time Week of 12/18/24 to 12/24/24- four times Week of 12/25/24 to 12/31/24- one time Week of 1/1/25 to 1/6/25- three times (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/7/25 to 1/8/25- one time The eMR tasks indicated Resident 64 used the rickshaw and pulley on 12/20/24, 1/1/25, and 1/6/24. The eMR tasks indicated Not Applicable was checked off for AROM to left and right lower extremity as follows: Week of 12/11/24 to 12/17/24- seven times Week of 12/18/24 to 12/24/24- two times Week of 12/25/24 to 12/31/24- four times Week of 1/1/25 to 1/6/25- three times 1/7/25 to 1/8/25- one time The eMR tasks indicated Not Applicable was checked off for leg ergometer as follows: Week of 12/11/24 to 12/17/24- seven times Week of 12/18/24 to 12/24/24- two times Week of 12/25/24 to 12/31/24- four times Week of 1/1/25 to 1/6/25- two times 1/7/25 to 1/8/25- one time The eMR tasks indicated Not Applicable was checked off for the rickshaw and pulley as follows: Week of 12/11/24 to 12/17/24- three times Week of 12/18/24 to 12/24/24- two times Week of 12/25/24 to 12/31/24- two times Week of 1/1/25 to 1/6/25- two times 1/7/25 to 1/8/25- one time RNA stated when Not Applicable was checked it meant I did not get to him that day. RNA stated Resident 64 was supposed to work with the RNA five days a week doing fifteen minutes on the bicycle, seven minutes on the rickshaw and seven minutes on the pulley for upper body strength, then 15 minutes of AROM on the legs as tolerated. RNA stated when she was off there was no one to cover for her and the other RNA would try to provide RNA therapy if she was available. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an interview on 1/9/25 at 12:23 p.m. with DON, DON stated Resident 64's RNA weekly summaries should have been done by the RNAs and they had not been completing them. During a review of the facility's policy and procedure (P&P) titled, Restorative Nursing Program Guidelines, dated 9/19/19, the P&P indicated, Procedure 1. The following criteria must be met in order to implement a restorative nursing program: A. Measurable objective and interventions are documented in the Care Plan and in the medical record. If a Restorative Nursing Program is in place when a Care Plan is being revised, it is appropriated to assess progress, goals, and duration/frequency as part of the care planning process. Good clinical practice would indicate that the results of this reassessment should be documented in the resident's medical record. B. Frequency of the RNA program will be determined by the medical necessity and physician order . V. The Interdisciplinary Care Plan will reflect the written plan of care for meeting the restorative needs of each resident including problems/needs, measurable goals and individualized approaches . VII. The RNA carries out the restorative program according on [sic] the Care Plan. The RNA documents the frequency of the program, the amount of time the resident spent in the activity and their tolerance to the program. In addition, the RNA completes a weekly summary for all residents on a Restorative Nursing Program.

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	555256	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rehabilitation Center of Bakersfield	2211 Mount Vernon Avenue Bakersfield, CA 93306

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 42744 Based on interview and record review, the facility failed to ensure one of eight sampled employees (Supervisor Licensed [SL] 3) had an annual performance evaluation completed. This failure had the potential to result in compromise to the health, safety, and well-being of residents. Findings: During an interview on 1/8/25 at 11:07 a.m. with Director of Nursing (DON), DON stated employees must have performance evaluations completed annually. During a concurrent interview and record review on 1/8/25 at 3:01 p.m. with Director of Staff Development (DSD), SL 3's personnel file (PF) was reviewed. SL 3's PF indicated SL 3's date of hire was 12/24/23 and there were no performance evaluations in the file. DSD stated SL 3 should have had a performance evaluation annually. During a review of the facility's Policy and Procedure (P&P) titled, Compliance as a Component of Employee Performance, dated 9/17/21, the P&P indicated, PURPOSE: Effective compliance programs required adherence to compliance as well as assurances that an employee's performance is evaluated and measured against the underlying expectations of the compliance program . PROCEDURE: . 2. The facility includes, as a component of the employee's annual performance evaluation, that the employee has awareness of and has adhered to the requirements of the facility's compliance program.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 27194 48901 Based on observation, interview, and record review, the facility failed to ensure the medication error rate was not greater than five percent (%) when five medication errors occurred within 39 opportunities resulting in a 12.82% error rate for three of six sampled residents (Resident 45, Resident 74, and Resident 107). This failure had the potential for Resident 45, Resident 74, and Resident 107 not receiving the full therapeutic effects of the medications and potential for adverse health outcomes. Findings: During an observation on 1/7/25 at 8:59 a.m. with Licensed Vocation Nurse (LVN) 2 in Resident 45's room, LVN 2 administered Mucus Relief (medication to help relieve congestion) 400 mg (milligrams) to Resident 45. During a concurrent interview and record review on 1/7/25 at 2:22 p.m. with LVN 2, Resident 45's Medication Administration Record (MAR), dated January 2025 was reviewed. The MAR indicated the following medications: Mucinex Allergy Tablet (Fexofenadine HCl - medication to treat allergies) Give 1 tablet by mouth two times a day for coughing/allergies and Fluticasone Propionate (medication to treat allergies) Suspension 50 MCG/ACT (micrograms/actuation) 1 spray in each nostril one time a day for allergies 2 stated she administered Mucus Relief instead of Mucinex Allergy, as that was the only medication in stock. LVN 2 stated she charted Fluticasone as administered at 9 a.m. but she did not actually administer it to the Resident 45. During an observation on 1/7/25 at 10:51 a.m. with LVN 3 in Resident 74's room, LVN 3 administered Naproxen (medication to treat fever and pain) 220 mg and Simethicone (medication to treat bloating and gas) 80 mg. During a concurrent interview and record review on 1/7/25 at 2:45 p.m. with LVN 3, Resident 74's MAR, dated January 2025 was reviewed. The MAR indicated, Naprosyn Oral Tablet (Naproxen) Give 220 mg by mouth three times a day for PAIN MANAGEMENT TAKE WITH FOOD, administration time 8 a.m. The MAR indicated, Simethicone Oral Tablet 80 MG (Simethicone) Give 1 tablet by mouth after meals and at bedtime for gas/bloating, administration time of 9 a.m. LVN 3 stated both medications were given past the allowed time. During a review of Resident 107's MAR, dated January 2025, the MAR indicated the following: Aspirin 81 Oral Tablet Chewable (Aspirin) Give 1 tablet via G-Tube one time a day.Docusate Sodium Liquid 50 MG/5ML Give 10 ml via G-Tube one time a day. Lisinopril Oral Tablet 10 MG (Lisinopril) Give 1 tablet via G-Tube one time a day. Pepcid Oral Tablet 20 MG (Famotidine) Give 1 tablet via G-Tube one time a day. Magnesium Oxide Oral Tablet 400 MG (Magnesium Oxide) Give 1 tablet via G-Tube Two times a day. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 1/8/25 at 10:17 a.m. in Resident 107's room, LVN 4 began to administer the following medications via Resident 107's gastrostomy tube (G-tube - a small flexible tube in the stomach to provide medications): Aspirin 81 (prevent blood clots) Oral Tablet Chewable, Docusate Sodium (to treat constipation) Liquid 50 MG/5ML (milliliters), Lisinopril (to treat high blood pressure) Oral Tablet 10 MG, Famotidine (to treat excessive stomach acid) 20 MG, Magnesium Oxide (to treat low magnesium levels) 400 MG. LVN 4 stated she had completed the medication administration at 10:18 a.m. and was going to dispose of the plastic medication cups from each medication. LVN 4 was asked by surveyor to recount the medications she had administered to Resident 107 and LVN 4 stated she had missed one crushed medication (unidentifiable) which remained in a medication cup. During a review of the facility's policy and procedures (P&P) titled, Medication - Administration, dated 1/1/12, the P&P indicated, Policy I. Medication will be administered directed by a Licensed Nurse and upon the order of a physician or licensed independent practitioner. Procedure I. Administration of Medications. B. The Licensed Nurse will prepare medications within one hour of administration. i. Medications may be administered one hour before or after the scheduled medication administered time. VI. Medication Rights A. Nursing Staff will keep in mind the seven rights of medication when administering medication. B. The seven rights of medication are: i. The right medication. iv. The right time.Documentation A. The time and dose of the drug or treatment administered to the patient will be recorded in the patient's individual medication record by the person who administered the drug or treatment.

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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. 50939 Based on observation, interview, and record review, the facility failed to implement infection control practices when: 1. No Enhanced Barrier Precaution (EBP-infection control strategy that uses Personal Protective Equipment [PPE-equipment worn to minimize exposure to a variety of hazards to reduce the spread of infections]) signage and no PPE supplies outside an EBP room for one of four sampled residents (Resident 18). 2. An opening in the wall between one of three clean and dirty utility rooms present. 3. One of one janitorial cart's trash bin did not have a lid. These failures had the potential to result in the spread of infection to Residents, staff, and visitors. Findings: 1. During a review of Resident 18's Admission Record, (AR) dated 1/8/25, the AR indicated Resident 18 had a gastrostomy (GT-tube inserted into an opening in the stomach for food). During a review of Resident 18's Physician Order, (PO) dated 1/4/25, the PO indicated, RESIDENT ON ENHANCED BARRIER PRECAUTION (EBP) TO REDUCE THE SPREAD OF MDRO [Multidrug-Resistant Organism that have become resistant to multiple antibiotics] INFECTIONS. During an observation on 1/6/25 at 10:45 a.m. in the hallway, there was no EBP signage or PPE supplies outside of Resident 18's room. During an interview on 1/6/25 at 4:25 p.m. with Infection Prevention Nurse (IPN), IPN stated there should had been EBP supplies outside of Resident 18's room. During a review of Resident 18's Care Plan, (CP) dated 1/4/25, the CP indicated, Focus: Enhanced Barrier Precautions: Resident required enhanced barrier precautions during high-contact resident care activities due to presence of GT. Interventions: Ensure items for following EBP are in place (Gloves, gown, alcohol-based hand rub signage) etc .Place EBP bin and signage at resident's doorway to alert staff of precautions. During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, dated 6/7/24, the P&P indicated, 5. Enhanced Barrier Precautions will be indicated by the presence of a brown bin outside of the room to notify caregivers of the EBP. 11. Follow the CDC (Centers of Disease Control and Prevention) and CMS (Centers for Medicare and Medicaid Services) guidance below, and/or state, local or county guidance as applicable: Table: Summary of Personal Protective Equipment (PPE) Use.Enhance Barrier Precautions.All residents with any of the following: Wounds and/or indwelling medical devices (e.g. feeding tube) 12. To facilitate compliance with EBP: a. Make PPE, including gowns and gloves, available immediately outside of the resident room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an interview on 1/7/25 at 1:50 p.m. with Infection Prevention Nurse (IPN), IPN stated there was a hole/opening in the wall between the clean utility room (clean and sterile medical supplies are stored) and dirty utility room (soiled medical equipment, used linen, and human waste are disposed of to prevent the spread of infection). During an observation on 1/7/25 at 1:54 p.m. in the C wing utility rooms, there was a hole between the clean utility and dirty utility room. The clean utility room contained an ice machine that was used for residents. The dirty utility room had two biohazard (risk to human health) bins, a large container with trash bags containing soiled briefs and wipes, and a large container with residents soiled linen. During a concurrent observation and interview on 1/8/25 at 9:49 am with Director of Maintenance (DOM) in the C wing utility rooms, DOM stated the hole between the clean utility room and dirty utility room measured 34.5 inches in width x 49 inches in length. During a review of the facility's P&P titled, Infection Control - Policies & Procedures, dated 1/1/12, the P&P indicated, Policy: The Facility's [sic] infection control policies and procedures are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. Requested Environmental P&P and none was provided. 3. During a concurrent observation and interview on 1/8/25 at 8:50 a.m. with Housekeeping Supervisor (HKS) on B wing, there was a janitorial cart trash bin without a lid. HKS stated the janitorial cart trash bin should have had a lid. During a concurrent observation and interview on 1/8/25 at 8:51 a.m. with Janitor on B wing, there was a janitorial cart trash bin without a lid. Janitor stated he had worked for the facility for three years and the janitorial cart trash bin never had a lid. During a concurrent observation and interview on 1/8/25 at 9:20 a.m. with IPN in the hallway, the janitorial cart trash bin did not have a lid. IPN stated, all of the [trash bin] carts should have a lid. During a review of the facility's P&P titled, Housekeeping - Staff Areas, dated 1/1/12, the P&P indicated, Purpose: To promote the health of residents and staff by maintaining clean and sanitary conditions.