STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555263	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Castle Manor Nursing & Rehabilitation Center	541 V Avenue National City, CA 91950

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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 - Some	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** 43518 Based on observation, interview, and record review the facility failed to ensure four of twenty-one sampled residents (12,17, 231, 233) had Advanced Directives or documented discussions with Social Services Director (SSD) about Advance Directives. This failure had the potential to prevent residents from making their own decisions in the case of emergency treatment. Cross Reference: F867 Findings: 1. Review of Resident 12's (R12) Admission Record dated 3/26/25 indicated R12 was admitted for diagnoses which included: Acute Respiratory Failure(a life-threatening condition where the lungs are unable to adequately exchange oxygen and carbon dioxide), Asthma(a chronic lung disease), Congestive Heart Failure(a chronic condition where the heart muscle is weakened and cannot pump blood effectively), Myocardial Infarction(another term for heart attack)and Pneumonia(an infection of the lungs). Review of R12's physician orders dated 3/26/25 indicated .Resident is (Capable) Of Understanding Rights, And Informed Consent. Review of R12's Minimum Data Set (MDS-standardized assessment tool used in Medicare and Medicaid certified nursing homes) Section C, dated 3/2/25, indicated that R12's Brief Interview for Mental Status (BIMs-a screening tool used to assess memory and orientation in nursing homes) was scored 15 which indicated intact cognition (thinking processes). Review of R12's Care Plan Report dated 3/26/25 indicated, .Resident has the right to .formulate an advance directive .Offer the opportunity for resident .to review/complete POLST (Physician Orders for Life-Sustaining Treatment-It is a medical document that outlines a patient's wishes regarding end-of-life care) form with Physician/Nurse Practitioner as needed . On 3/24/25 at 8:30 A.M., a record review of the electronic medical record (EMR-computer based charting) was conducted for R12. No advanced directive or POLST were in the EMR. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/24/25 at 9 A.M., a record review or R12's paper chart was conducted. No POLST or advance directive were found in the paper chart. On 3/25/25 9:02 A.M., a concurrent interview and record review was conducted with Licensed Nurse 21 (LN21). LN21 stated she was not able to find an advanced directive in paper chart or in EMR for R12. LN21 stated that a particular physician .only writes an order for full code for all his residents and does not fill out Advance Directives for his residents . On 3/25/25 at 3 P.M., an interview with R12 was conducted. R12 stated that she had been at the facility over a month and could not remember a conversation with a physician or other staff about an Advanced Directives. R12 stated that she would not like to be put on machines to keep her alive in an emergency or be fed thru a tube. On 3/26/25 at 9:50 A.M., a concurrent interview with Director of Social Services (DSD) and record review of Advanced Directives for the following residents(12, 17, 231, 233)were conducted. The DSD stated that she could not find any documentation for Advance Directive discussions prior to admission for the four sampled residents. The DSD stated the process for Advanced Directives was to meet with the resident a few days prior to being admitted , and the interdisciplinary team discusses plan of care for resident, including Advance Directives. The DSD stated she only would document if the resident wanted more information about Advanced Directives, and not if they refused. The DSD stated that an order for full treatment during a code blue (resident stops breathing and heart has stopped beating) situation is not the same as an Advanced Directive. The DSD stated that the expectation for Advanced Directives was that after discussing with resident, it should be documented in resident's medical record if the resident wanted more information or if resident refused information about Advanced Directives. The DSD stated that the importance of discussing Advanced Directives with resident and documenting that they were discussed was to the protect the resident's right to decide what type of treatment they want during a medical emergency. On 3/27/25 at 9:40 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated that expectation was that the SSD would discuss Advance Directives with residents prior to admission and document if they had advance directives, if they wanted more information, or if they refused Advance Directives. The DON stated that the importance of discussing and documenting Advanced Directives with residents was to give residents the ability to express their choices of care in the case of a medical emergency. 47466 2. Resident 231 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus (abnormal blood sugar) and chronic obstructive pulmonary disease (chronic lung disease causing difficulty in breathing). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 3/26/25 at 9:00 A.M., was conducted with Resident 231. Resident 231 stated she signed a lot of paperwork when she came but she is not sure of the Advanced Directive (a legal document indicating resident preference on end-of-life treatment decisions) and the Physicians Order for Life Sustaining Treatment (POLST - a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life). Resident 231 stated she does not remember signing either one but stated she wants to be resuscitated in case her heart stops at some point . A record review of Resident 231 's Minimum Data set (MDS- a federally mandated assessment tool) dated 3/23/25 indicated Resident 231's brief interview for mental status (BIMS) score was 15 which meant Resident 231's cognition(thinking processes) was intact. A review on 3/26/25 indicated Resident 231 did not have an Advanced Directive or a POLST per her medical record but her Physician's order sheet indicated Resident 231 was a full code. An interview on 03/26/25 at 11:01 A.M., was conducted with licensed nurse (LN) LN 31. LN 31 stated it was important, so they know what to do in case of emergency since the emergency staff usually asked for the POLST and respect what Resident 231's desires were. 3. Resident 233 was admitted on [DATE] to the facility with diagnoses that included history of falls and Hypertension (high blood pressure). An interview on 3/26/25 at 9:00 A.M., was conducted with Resident 233. Resident 233 stated she was not offered an Advanced Directive or a POLST when she was admitted to the facility. Resident 233 stated she wanted to be resuscitated in case something happens. A record review of Resident 233's Minimum Data set (MDS- a federally mandated assessment tool) dated 3/17/25 indicated Resident 233's brief interview for mental status (BIMS) score was 15 which meant Resident 233's cognition(thinking processes) was intact. A review of Resident 233's medical record indicated Resident 233 did not have an Advanced Directive nor a POLST, but her Physicians order sheet (POS) indicated she was a full code. An interview on 3/25/25 at 3:07 P.M., was conducted with licensed nurse (LN 32). LN 32 stated she cannot find the POLST or an Advanced Directive in Resident 233's medical record. LN 32 stated it was important to have the Advance Directive and the POLST in Resident 233's medical record, to respect their choice if something happens. LN 32 stated it was the Social Service Director (SSD) responsibility to make sure the advanced directive and POLST were done. On 3/26/25 at 9:50 A.M., a concurrent interview with Director of Social Services (DSD) and record review of Advanced Directives for the following residents(12, 17, 231, 233)were conducted. The DSD stated that she could not find any documentation for Advance Directive discussions prior to admission for the four sampled residents. The DSD stated the process for Advanced Directives was to meet with the resident a few days prior to being admitted , and the interdisciplinary team discusses plan of care for resident, including Advance Directives. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DSD stated she only would document if the resident wanted more information about Advanced Directives, and not if they refused. The DSD stated that an order for full treatment during a code blue (resident stops breathing and heart has stopped beating) situation is not the same as an Advanced Directive. The DSD stated that the expectation for Advanced Directives was that after discussing with resident, it should be documented in resident's medical record if the resident wanted more information or if resident refused information about Advanced Directives. The DSD stated that the importance of discussing Advanced Directives with resident and documenting that they were discussed was to the protect the resident's right to decide what type of treatment they want during a medical emergency. On 3/27/25 at 9:40 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated that expectation was that the SSD would discuss Advance Directives with residents prior to admission and document if they had advance directives, if they wanted more information, or if they refused Advance Directives. The DON stated that the importance of discussing and documenting Advanced Directives with residents was to give residents the ability to express their choices of care in the case of a medical emergency. 49330 4. According to the Admission Record, Resident 17 was admitted on [DATE] with diagnoses that included Type 2 diabetes(condition with abnormal blood sugar) and depression. A review of the Minimum Data Set (MDS-an assessment tool) dated 1/14/25 indicated Resident 17 had a BIMS (tool to assess cognition) score of 13 indicating intact cognition(thinking processes). During a review of Resident 17's medical records, an Advanced Directive was not found in her electronic medical record or physical chart. On 3/26/25 at 9:10 A.M., an interview was conducted with Resident 17. Resident 17 stated she did not have an Advanced Directive, and that she wanted to initiate one. Resident 17 stated staff had not discussed an Advanced Directive with her. Resident 17 stated, .I think I had something like that a long time ago. I have four granddaughters that could help me with that . On 3/26/25 at 9:50 A.M., a concurrent interview with Director of Social Services (DSD) and record review of Advanced Directives for the following residents(12, 17, 231, 233)were conducted. The DSD stated that she could not find any documentation for Advance Directive discussions prior to admission for the four sampled residents. The DSD stated the process for Advanced Directives was to meet with the resident a few days prior to being admitted , and the interdisciplinary team discusses plan of care for resident, including Advance Directives. The DSD stated she only would document if the resident wanted more information about Advanced Directives, and not if they refused. The DSD stated that an order for full treatment during a code blue (resident stops breathing and heart has stopped beating) situation is not the same as an Advanced Directive. The DSD stated that the expectation for Advanced Directives was that after discussing with resident, it should be documented in resident's medical record if the resident wanted more information or if resident refused information about Advanced Directives. The DSD stated that the importance of discussing Advanced Directives with resident and documenting that they were discussed was to the protect the resident's right to decide what type of treatment they want during a medical emergency. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/27/25 at 9:48 A.M. an interview was conducted with the Director of Nursing (DON). The DON stated it was important to discuss Advanced Directives with residents upon admission. The DON stated it was important to honor residents' wishes. Review of the facility policy titled ADVANCED DIRECTIVES dated 2016, indicated that .1. Prior to or upon admission of a resident .the Social Services Director or designee will provide written information to the resident concerning his/her right to make decisions .including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives .3. Prior to or upon admission .the Social Services Director or designee will inquire of the resident and/or his/her family members, about the existence of any written advance directives. 4. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record .

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45063 Based on observation, interview and record review, the facility failed to ensure confidential information was kept private for one of 4 sampled residents (181) when Licensed Nurse (LN) 11 left Resident 181's bubble wrap medications (unit dose packaging organizing medications into individual doses) unattended. As a result, Resident 181's right to privacy and confidentiality was violated. Findings: Resident 181 was admitted to the facility on [DATE] with diagnoses which included fracture (complete or partial brake in a bone) of superior rim of right pubis (upper edge of right pubic bone) per the facility's Admission Record. On 3/26/25 at 10:32 A.M., an observation of LN 11, during medication administration in room [ROOM NUMBER] A was conducted. LN 11 left three (3) bubble wrap medications of resident 181 over a medication cart, outside room [ROOM NUMBER] A, unattended. The bubble wrap medications contained residents name, medication's name and dosage (Lexapro 5 mg one tab daily- a medication for depression, Losartan 25 mg one tab daily- a medication for blood pressure control, Namenda 10 mg one tab twice a day- a medication for dementia[decline in mental ability]) . On 3/26/25 at 10:45 A.M., an interview with LN 11 was conducted. LN 11 stated he should have not left resident 181's bubble wrap medications over the cart, exposed to the general public, unattended. LN 11 acknowledged it was a privacy and HIPAA (Health Insurance Portability and Accountability Act,- a federal law that sets national standards for protecting sensitive patient health information) issue. On 3/27/25 at 8:55 A.M., an interview with Charge Nurse (CN) 11 was conducted. CN 11 stated residents bubble wrap medications should have been placed inside the locked medication cart. CN 11 further stated leaving a resident's bubble wrap medications unattended was a privacy and HIPAA issue. On 3/27/25 at 1:10 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated Resident 181's bubble wrap medications should have not been left unattended over the cart. The DON stated resident's bubble wrap medications contained resident's name and medication. The DON stated the expectation was for LN 11 to put resident 181's bubble wrap medications inside the locked cart before going in to Resident 181's room. The DON stated it violated Resident 181's privacy and confidentiality. Per the facility's policy titled, Confidentiality of Information and Personal Privacy, revised October 2017, indicated, . Policy Interpretation and Implementation .1. The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49330 Based on observation, interview and record review the facility failed to implement an individualized care plan for one of twenty-two sampled residents (Resident 41) with pruritis (itching) and rashes. This failure had the potential for Resident 41 to experience continued discomfort and skin breakdown. Findings: According to the Admission Record, Resident 41 was admitted on [DATE] and readmitted on [DATE] with diagnoses which included need for assistance with personal care. A review of the Minimum Data Set (MDS-an assessment tool) indicated Resident 41 had a BIMS (a score to measure cognition) of 15, indicating Resident 41 was cognitively(thinking processes) intact. On 03/24/25 at 8:30 A.M., an observation and interview was conducted with Resident 41. Resident 41 stated he was diagnosed with scabies (a rash caused by a tiny mite which causes intense itching) in January 2025. Resident 41 lifted up his shirt and multiple red bumps were observed on his shoulders,chest, and stomach. Resident 41 stated, .These [rashes] overrun me .they're eating me up .they gave me scabies .they're hearty little suckers! Resident 41 stated although he had been treated for scabies, he is still experiencing intense itching. On 3/26/25 at 2:08 P.M., a joint interview and record review was conducted with the Treatment Nurse (TN). The TN stated he was aware that Resident 41 had been treated for scabies, but did not know that Resident 41 still had an itchy rash. The TN stated there was no written care plan for Resident 41 that addressed the rash. The TN stated it was important to have a care plan to see what can be done to treat Resident 41, and to reassess to see if the plan was effective. The TN stated, .We also need to update it as needed. If the original plan isn't working, if he is still itching, we should have updated it to help the resident . On 3/27/25 at 9:48 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated Resident 41 should have had a care plan to address his itchy rashes, even after he was already treated for scabies. The DON stated, We should have started a care plan when [the scabies] was first diagnosed and updated [the care plan] as it progressed to see if the interventions were working or not working . A review of the facility's policy titled Care Plans, Comprehensive Person-Centered, revised March 2022 indicated, A comprehensive, person-centered care plan that includes measureable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49330 Based on observation, interview, and record review the facility failed to provide care consistent with professional standards of practice to prevent pressure injuries (skin breakdown caused by pressure) for one of twenty-two sampled residents (Resident 1) by failing to turn/reposition resident and failing to provide pericare (cleaning the private area) for an extended period of time. This failure had the potential to result in the decline of Resident 1's skin integrity. Findings: Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] according to the Admission Record with diagnoses which included multiple sclerosis (a condition which affects the nerves and causes weakness and numbness) and dementia (a condition which causes memory impairment and affects daily functioning). A review of Resident 1's Braden Scale For Predicting Pressure Sore Risk dated 1/9/25 indicated a Score of 11, which indicated Resident 1 was at High Risk for developing pressure injuries. A review of Resident 1's MDS (Minimum Data Set-an assessment tool) dated 1/9/25 indicated Resident 1 was dependent on staff to perform all Activities of Daily Living (ADL's-daily care such as bathing, dressing, toileting etc). On 3/24/25 the following observations were made: -8:20 A.M. Resident was positioned supine (lying facing upward) on her back. -10:15 A.M. Resident was positioned supine on her back. -11:22 A.M. Resident was positioned supine on her back. -1:33 P.M. Resident was on her back with the head of bed at 90 degrees. -2:45 P.M. Resident was on her back with the head of bed at 90 degrees. On 3/25/25 the following observations were made: -8:20 A.M. Resident was sitting in a wheelchair -9:24 A.M. Resident was sitting in a wheelchair. -2:08 P.M. Resident was sitting in a wheelchair. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/25/25 at 2:08 P.M., an interview was conducted with Licensed Nurse 12 (LN 12). LN 12 stated, .I would say [Resident 1] is at high risk for [skin] breakdown. She's incontinent, she's very dependent on ADL's, she has limited range of motion, she doesn't move much in bed, or in the chair . LN 12 stated her expectation was for the resident to be turned as frequently as 2 hours. On 3/25/25 at 2:11 P.M., an interview was conducted with Certified Nursing Assistant 11 (CNA 11). She stated resident was up in her wheelchair when she started her shift at 7:30 A.M. CNA 11 stated Resident 1 had not been repositioned in the wheelchair. CNA 11 stated she had not provided pericare for Resident 1 yet. CNA 11 stated, .We should have checked her every 2 hours to see if she is wet .she is would get a bedsore if she stays up for a long time . On 3/27/25 at 9:08 A.M. an interview was conducted with the Director of Nursing (DON). The DON stated, The resident should be repositioned, even if she's in the wheelchair. We are trying to prevent the reopening of wounds. We also want to prevent any new wounds . A review of the facility's policy titled Repositioning revised May 2013 indicated, Interventions .3. Residents who are in bed should be on at least an every-two-hour (q2 hour) repositioning schedule .5. Residents who are in a chair should be on an every-one-hour (q1 hour) repositioning schedule .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49330 Based on observation, interview and record review, the facility failed to follow its policy on smoking procedures for one of twenty-two residents (Resident 41) reviewed for smoking. As a result, there was potential to jeopardize the health and safety of Resident 41. Findings: According to the Admission Record, Resident 41 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included nicotine(addictive substance found in tobacco) dependence and need for assistance with personal care. A review of the Minimum Data Set (MDS-an assessment tool) indicated Resident 41 had a BIMS (a score to measure cognition) of 15, indicating Resident 41 was cognitively (thinking processes) intact. On 3/24/25 at 8:30 A.M., an interview was conducted with Resident 41. Resident 41 stated he was upset because he wanted to go outside to smoke a cigarette, but staff took his cigarettes away from him yesterday. Resident 41 stated he used to go outside to smoke cigarettes whenever he wanted to. Resident 41 stated, I smoke, all of a sudden yesterday, I need to have a baby sitter go with me in the patio .prior to yesterday I had it [cigarettes and lighter] with me .there's never been a problem with me smoking . On 3/24/25 at 2 P.M., Resident 41 was observed in the patio, smoking a cigarette. There was a staff member present and was supervising Resident 41 while he was smoking. Resident 41 stated he agreed to go to a supervised smoke break, .I gave in a little .they won and I won . Resident 41 stated he was upset because, .I always stored my cigarettes in my room .They never tried to stop me [from going outside to smoke unassisted] until yesterday . On 3/24/25 at 2:04 P.M. an interview was conducted with the Activities Director (AD). The AD stated the facility policy was that all smokers needed to be supervised by staff during scheduled smoke breaks, and that cigarettes and lighters would be kept by staff. The AD stated Resident 41 had a history of going outside by himself, without staff supervision, to smoke cigarettes. The AD stated, .[Resident 41] signed the smoking agreement, but he's not following the rules .we had IDT meetings [Interdisciplinary-a group of professionals with different areas of expertise] . The AD stated the IDT notes would be found in Resident 41's electronic medical record. On 3/25/25 at 2:43 P.M. an interview was conducted with Licensed Nurse (LN) 13. LN 13 stated, Resident 41 is not safe to smoke outside by himself. He could get burned with ashes or start a fire. He could hurt himself or other residents . LN 13 acknowledged Resident 41 kept cigarettes and a lighter in his possession, and was noncompliant with the facility rules for smoking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/25 at 2:21 P.M. an interview was conducted with the Social Services Assistant (SSA). The SSA stated, an incident occurred several weeks ago in Resident 41's room. The SSA stated, .I went [into Resident 41's bedroom] with the nurse, I remember seeing him with a cigarette lit in his mouth . The SSA stated she confiscated Resident 41's cigarettes, but she does not know how he got them back. On 3/26/25 at 3:47 P.M., an interview was conducted with Licensed Nurse (LN)14. LN 14 stated she observed Resident 41 smoking a lit cigarette in his room. LN 14 stated, I called the Social Services Assistant . she spoke to [Resident 41] and took his cigarettes away . LN 14 stated, .I forgot to remove the cigarettes from his room .We all need to be on the same page on what is the action for him .we should have done an IDT. It wasn't safe. He can hurt himself and others . A review of Resident 41's Progress Notes dated 12/26/24 indicated, SSA was told that resident is smoking in his room. SSA and charge nurse went to patient [sic] room, and he is till [sic] smoking his cigarette. SSA asked for his cigarette, and he handed it over and he stated that he thought that he is outside smoking. SSA told him that he cannot smoke at all inside the facility only at the designated areas and he is verbalizing of understanding. SSA took his cigarette and his lighter and made him aware that if he needs to smoke to ask the charge nurse so that he can be accompanied at the smoking area, and he is verbalizing of understanding . A review of Resident 41's Electronic Health Record (EHR) indicated Resident 41 had a Smoking Risk assessment completed on 1/15/25. There was no record that a Smoking Risk Assessment was completed when Resident 41 was admitted on [DATE], and when readmitted on [DATE]. A review of Resident 41's EHR indicated there was no IDT note done when Resident 41 was found smoking a cigarette inside the facility. On 3/27/25 at 9:48 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated, . We should have addressed the smoking, make sure we documented what we did about it. The IDT should have been notified .to keep [Resident 41] and other patients safe . A review of the facility's undated policy titled Smoking Policy indicated, .Smoking is only permitted in designated resident smoking areas .Smoking is not allowed inside the facility under any circumstances . Resident smoking status is evaluated upon admission. If a smoker, the evaluation includes .d. ability to smoke safely with or without supervision .13. Resident smoking material(s) will be secured and stored at the nursing station .

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	555263	A. Building B. Wing	03/27/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43518 Based on observation, interview, and record review the facility failed to ensure medications were administered appropriately for two of twenty-one sampled residents (41, 133). This failure had the potential for medication error resulting in decline in residents' health. Findings: 1. Review of Admission Record for Resident 133 (R133), dated 2/26/25 indicated that R133 was admitted with diagnoses that included: End Stage Renal Disease (a condition where the kidneys have permanently lost their ability to function adequately), Dysphagia (difficulty swallowing), Pneumonia (an infection of the lungs), and Congestive Heart Failure (a condition where the heart is unable to pump blood effectively). Review of Order Summary Report, dated 3/26/25, indicated Renal diet. Pureed texture. Thin Liquids consistency .per family request .Nepro with meals for Supplement .May crush medications unless contraindicated . On 3/24/25 at 9:36 A.M., an observation of R133's room was conducted during initial tour. R133 was asleep. A cup of Renal supplement (supplemental shake) with a straw and a used medication cup with residual medicine mixed with supplement observed on bedside table. On 3/24/25 at 9:47 A.M., a concurrent observation of R133's bedside table and interview with Licensed Nurse 22 (LN22) was conducted. LN22 stated that she was giving the resident crushed medication and supplement mixed in the medication cup, and that she had left some of the medication in the cup. LN22 stated the expectation for administering medications was to give the medication and dispose of the medication cup that it was mixed in after. LN22 stated that the importance of giving as much of the medication in the cup was to make sure R133 received the full dose of medication ordered. In addition, LN 22 stated disposing the medication cup after it was used prevented other residents from taking any residual medication in the cup. On 3/24/25 at 9:51 A.M., a concurrent observation of R133's bedside table and interview with Licensed Nurse 21 (LN21) was conducted; LN21 was the charge nurse on that unit. LN21 stated it appeared there was medication and supplement mixed in the medication cup, and that she had left some of the medication in the cup. LN21 stated the expectation for administering medications was to give the medication and dispose of the medication cup that it was mixed in after. LN21 stated that the importance of giving as much of the medication in the cup, and then disposing the cup after is to prevent other residents from taking the medication. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/27/25 at 9:40 A.M., a concurrent observation of a photo of R133's bedside table with medication cup and interview with the Director of Nursing (DON) was conducted. The DON stated the expectation for administering medication was that if crushing the medicine, the resident should receive as much of the medicine as possible from the container, and the LN should dispose of the container after medication administered. The DON stated that the importance of LN's giving the resident all the medication crushed in the cup was that the resident needed to receive the ordered dose of the medication. In addition, the DON stated the importance of discarding used medication cups was to prevent other residents from accidentally ingesting medication in error. 49330 According to the Admission Record, Resident 41 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Type 2 Diabetes (a condition that affects how the body uses sugars) with diabetic neuropathy (a disease of the nerves causing numbness or weakness) and need for assistance with personal care. A review of the Minimum Data Set (MDS-an assessment tool) indicated Resident 41 had a BIMS (a score to measure cognition) of 15, indicating Resident 41 was cognitively intact. On 3/26/25 at 2:07 P.M., during an interview with Resident 41, a plastic medicine cup with a yellow capsule was observed on Resident 41's bedside table. Resident 41 stated, .The nurse brought it here and put it on my table. I just forgot to take it earlier . On 3/26/25 at 2:10 P.M. an interview was conducted with Licensed Nurse (LN) 5. LN 5 stated she brought the capsule in at 1 P.M. but she turned her back and did not see Resident 41 take the medication. LN 5 stated, .I should have made sure that he swallowed it, to make sure that he took it .to make sure he got the proper dose of the medication. Also, [the bedside table] is really close to his door so we don't want anyone else to take it .it's not safe to leave a medication there . LN 5 stated since the medication was due at 1 P.M., it was now being given late. On 3/27/25 at 9:48 A.M. an interview was conducted with the Director of Nursing (DON). The DON stated, . Medications should never be left with the resident because you can't ensure residents took it . The DON stated it was important that the nurses make sure the medication is taken before leaving the resident because there was a chance another resident could come in and take it. A review of the facility's policy titled Administering Medications, dated 2001, indicated, .Medications are administered in a safe and timely manner, and as prescribed .

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 43518 Based on interview and record review the facility's Quality Assessment and Assurance Committee (QAA-facility group that monitors concerning trends in a facility) failed to identify and include in the facility's Quality Assurance Performance Improvement plan (QAPI-plan developed by QAA to help improve conditions in the facility), trends found by surveyors during the recertification survey concerning Advance Directives (a legal document that allows you to make decisions about your future medical care). This failure had the potential for the facility to overlook trends in resident care that might have affected residents' dignity and/or health. Cross Reference: F578 Findings: On 3/27/25 at 2:15 P.M., a concurrent interview with the Administrator (ADM) and the Director of Nursing (DON) and a review of QAPI program was conducted during QAPI task. The ADM stated that the main areas that the QAPI team were monitoring were Falls and Skin Care. During the recertification survey, deficient trends in Advanced Directives were identified by surveyors. The ADM stated that this trend had not been identified by the QAA Committee and/or included in the QAPI plan. On 3/27/25 at 2:30 P.M., an interview with the ADM was conducted. The ADM stated that the expectation was the QAA Committee should have identified the deficient trend with advanced directives that was identified by the surveyors during recertification survey. In addition, the ADM stated the deficient trend should have been included in the QAPI plan. The ADM stated the importance of QAA Committee identifying deficient trends and including them in the QAPI plan was to promote the highest standard of care for their residents. Review of facility policy titled Quality Assurance and Performance Improvement (QAPI) Program-Governance and Leadership dated March 2020, indicated .4. The responsibilities of the QAPI committee are to: .b. Identify, evaluate, monitor, and improve facility systems and processes that support delivery of care and services; c. Identify and help to resolve negative outcomes and/or care quality problems identified during the QAPI process . Review of facility policy titled, Quality Assurance and Performance Improvement (QAPI) Program, dated February 2020, indicated .Implementation .The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components include .c. Identifying and prioritizing quality deficiencies . Review of the facility policy titled, Quality Assurance and Performance Improvement (QAPI) Program-Analysis and Action, dated March 2020, indicated .1. The QAPI program, overseen by the QAPI committee is designed to identify and address quality deficiencies through the analysis of the underlying cause and actions targeted at correcting systems at a comprehensive level . (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled, Quality Assurance and Performance Improvement (QAPI) Program-Design and Scope, dated February 2020, indicated .1.The QAPI Program is designed to address all systems and practices in this facility that affect residents, including clinical care, quality of life, resident choice and safety . 4. The QAPI functions prioritizes identified problem areas that are high risk, high volume, and/or problem prone . Review of the facility policy titled, Quality Assurance and Performance Improvement (QAPI) Program-Feedback, Data, and Monitoring, dated March 2020, indicated .2. The QAPI process focuses on identifying systems and processes that may be problematic and contributing to avoidable negative outcomes related to resident care, quality of life, resident safety, resident choice or resident autonomy, and on making good faith effort to correct or mitigate these outcomes .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49330 Based on observation, interview, and record review the facility failed to demonstrate infection control practices when: 1. A staff member was observed leaving an isolation room wearing full Personal Protective Equipment (PPE-gown, gloves, mask, face shield). and 2. A staff did not perform hand hygiene for one of 4 sampled residents (34) during medication administration. As a result, residents were at risk for exposure to unwanted pathogens (microorganisms that cause disease). Findings: 1. On 3/26/25 at 9:20 A.M., an observation was conducted outside Resident 401's room. There was a contact/droplet sign posted outside Resident 401's room. There was a plastic PPE cart outside the room with tub of sanitizer on top. Physical Therapist (PT) 1 was observed opening the door wearing full PPE, and picked up the tub of sanitizer with gloved hands. PT 1 took the tub of sanitizer inside the room and closed the door. PT 1 was observed opening the door and placing the container back on top of the PPE cart. On 3/26/25 at 9:23 A.M., PT 1 was observed exiting the room holding a walker and a face shield. On 3/26/25 at 2:25 P.M. an interview was conducted with PT 1. PT stated he was wearing full PPE inside the room because Resident 401 had Covid-19. PT 1 stated, I shouldn't have left the room wearing PPE, especially in a Covid room. On 3/27/25 at 9:48 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated, . Proper precautions should've been taken. [Staff] needs to make sure they're taking PPE off inside the room to avoid spreading Covid .since we're currently in an outbreak . A review of the facility's policy titled Personal Protective Equipment revised 10/2018 indicated, .PPE required for transmission-based precautions is maintained .inside the resident's room, as needed . 45063 2. Resident 34 was readmitted to the facility on [DATE] with diagnoses which included Acute Osteomyelitis (a serious infection of the bone that develops rapidly) per the facility's Admission Record. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/25 at 8:14 A.M., an observation of Licensed Nurse (LN) 11, during medication administration in room [ROOM NUMBER] B was conducted. LN 11 had a pair of gloves on during the following activities; First LN 11 took Resident 34's blood pressure, then went on to touch the side table and radio. LN 11 then proceed to check on Resident 34's G-tube (Gastrostomy tube- a thin flexible tube inserted through the abdominal wall and into the stomach) patency. LN 11 further proceed to touch the privacy curtains two times, then went to touch the G-tube again while trying to de-clog the tube. LN 11 used the same gloves and did not perform hand hygiene in between activities. On 3/26/25 at 11:05 A.M., an interview with LN 11 was conducted. LN 11 stated he should have performed hand hygiene and changed his gloves after touching Resident 34's personal belongings and privacy curtains and before touching Resident 34's G- tube. LN 11 stated hand hygiene was important to prevent cross contamination. On 3/27/25 at 8:52 A.M., an interview with Charge Nurse (CN) 11 was conducted. CN 11 stated LN 11 should have performed hand hygiene and put on a new pair of gloves while providing care and in between touching Resident 34's belongings and privacy curtain to prevent cross-contamination and the spread of infection. On 3/27/25 at 9:12 A.M., an interview with Infection Preventionist (IP) was conducted. The IP acknowledged LN 11 should have performed hand hygiene and put on a new pair of gloves after touching Resident 34's environment but did not. The IP further stated this should have been done to prevent cross-contamination. On 3/27/25 at 1:10 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated the expectation was for LN 11 to perform hand hygiene and changed his gloves in between touching Resident 34's environment and providing care to prevent cross-contamination. Per the facility's policy titled, Handwashing/Hand Hygiene, revised October 2023, indicated, Policy . Indications for Hand Hygiene .1. d. after touching a resident; e. after touching the residents' s environment .