STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555272	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atherton Baptist Home	214 South Atlantic Blvd. Alhambra, CA 91801

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on interview and record review, the facility failed to ensure resident received reasonable accommodation of needs for one of 22 sampled residents (Resident 9) by failing to ensure resident was in a comfortable position during meals. This deficient practice resulted in Resident 9 in feeling exhausted and uncomfortable while eating. Findings: During a record review of Resident 9's Admission Record, the Admission Record indicated Resident 9 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of spinal stenosis (a tightening of the spinal canal that causes nerve pain), osteoporosis (weakening of bones, leading to a decrease in bone density and an increased risk for fractures), and reduced mobility. During a record review of Resident 9's Minimum Data Set (MDS, a federally mandated resident assessment and tool), dated 10/29/2024, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was moderately impaired. The MDS indicated Resident 9 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) for eating. During a record review of Resident 9's care plan, dated 8/26/2024, the care plan indicated Resident 9 had a potential for alteration in nutrition related to lack of coordination, spinal stenosis (narrowing of the spine which puts pressure on the spinal cord and nerves), and decline in activities of daily living. The care plan interventions were to assess likes and dislikes, provide needed assistance during meals, and monitor through nutrition alert meeting as needed. During an observation on 11/4/2024 at 12:10 PM in the dining room, Resident 9 was sitting on the dining chair and the dining table was at Resident 9's eye level. Resident 9 held the lunch plate on her lap with her left hand while she used her right hand to feed herself. (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation in the dining room and interview on 11/4/2024 at 12:17 PM with Restorative Nursing Aide (RNA 1), RNA 1 stated Resident 9 was hunched and sitting in the chair. RNA 1 stated every time Resident 9 was straightened up she would go back to the hunched position. RNA 1 stated they had tried to add cushion to her chair to make her higher so she could eat on the table, but Resident 9's feet would hang on the chair and Resident 9 did not like her feet to hang. RNA 1 stated the table was high for Resident 9. RNA 1 stated Resident 1 was eating with her plate on her lap. RNA 1 stated Resident 9 ate with her plate on her lap all the time. During an observation on 11/4/2024 at 12:24 PM of Resident 9 in the dining room, Resident 9 finished eating lunch and placed her plate and cup on the table, she sighed and stated, I'm exhausted. During an interview on 11/7/2024 at 8:53 AM with Resident 9, Resident 9 stated when she ate in the dining room, she could not reach her food on the dining table. Resident 9 stated staff put her plate on the table, and she tried to eat on the table. Resident 9 stated she got tired, and it was not comfortable eating on the table since the table was so high for her. Resident 9 stated it was hard to eat with the plate on the table since she had to tilt her head back each time she ate. Resident 9 stated it was horrible since the table was too high. Resident 9 stated, It's like feeding a midget. Resident 9 stated it was ideal for her to eat at the table instead of holding her plate on her lap while eating but felt that holding her plate was better than reaching up to the table while eating. Resident 9 stated when she reached up to the table to eat, it hurt all over her bones and was not comfortable. Resident 9 stated she was always placed at the regular table where it was too high for her. Resident 9 stated, I don't think people realize it, it's hard for me to eat like that. During an interview on 11/7/2024 at 9:35 PM with the Director of Nursing (DON), the DON stated residents should eat at their comfortable level. The DON stated the table should be above the waist and the residents' hands should be resting comfortably on the table. The DON stated the table should not be positioned at the residents' face while eating since this was not the proper way for a resident to be positioned while eating. The DON stated this could result in a bad posture while eating, cause discomfort and place the residents at risk for aspiration (inhaling small particles of food or drops of liquid into the lungs). During a record review of the facility's Policy and Procedure titled, Quality of Life - Accommodation of Needs, revised 11/2010, the policy indicated the resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, shall be evaluated upon admission and reviewed on an ongoing basis.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on interview and record review, the facility failed to follow its Change in a Resident's Condition or Status policy by failing to notify the physician regarding a significant weight loss for one of three sampled residents (Resident 31) as indicated on the care plan. This deficient practice had the potential to result in delayed provision of necessary care and services. Findings: During a record review of Resident 31's Admission Record indicated Resident 31 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of hyperlipidemia (a condition in which there are high levels of fat particles in the blood), dementia (progressive brain disorder that slowly destroys memory and thinking skills) and left artificial hip joint. During a record review of Resident 31's Weight Tracking System Report, the record was as follows: - 5/29/2024 184 lbs - 6/3/2024 184 lbs - 6/6/2024 161 lbs (-23 lbs in three days, 12.5% weight loss) - 6/10/2024 160 lbs (-24 lbs, 13.0% weight loss) During a record review of Resident 31's Nutrition Risk Assessment, dated 6/3/2024, the record indicated care planned weight goal was to maintain weight 184 lbs plus or minus six (6) lbs by the next review. During a record review of Resident 31's Interdisciplinary Notes, dated 6/10/2024, the record indicated a weekly weight loss of 23 lbs and the physician was notified of the weight loss (4 days after). During a record review of Resident 31's Registered Dietician Notes, dated 6/11/2024, the record indicated Resident 31 was referred to nutrition alert due to 24 pounds, 13.0% weight loss in the past week. During a record review of Resident 31's Minimum Data Set (MDS, a federally mandated resident assessment and tool), dated 8/26/2024, the record indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was intact. The MDS indicated Resident 31 required substantial/ maximal assistance (helper does more than half the effort) for shower/bathe self, upper and lower body dressing, and chair/bed-to-chair transfer. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 31's nutrition care plan, dated 9/25/2024, the care plan indicated monitor weekly weights per facility protocol, report significant changes in weight to physician and registered dietician. During an interview on 11/6/2024 at 3:28 PM with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated Resident was 184 lbs upon admission on 5/28/2024. LVN 2 stated on 6/3/2024 Resident 31 was still 184 lbs, then three days later Resident 31 weighed 161 lbs (-23 lbs). LVN 2 stated five (5) lbs weight loss in one week or one month needed to be reported to the physician. LVN 2 stated the physician needed to assess Resident 31 for her weight loss. LVN 2 stated the physician and registered dietician needed to be contacted as soon as the weight loss was noted. During a concurrent record review of Resident 31's electronic medical records with LVN 2, LVN 2 stated there was no physician notification on 6/6/2024 for Resident 31's weight loss. LVN 2 stated the physician should have been contacted as soon as they were contacted by the Restorative Nursing Aide of Resident 31's weight. LVN 2 stated the licensed nurses still needed to notify the physician since Resident 31's weight loss was more than 5 lbs. LVN 2 stated the physician should have been informed since Resident 31 might not be eating, have a poor appetite, require laboratory work, and require physician intervention to determine the reason why Resident 31 lost weight. During an interview on 11/7/2024 at 9:41 PM with the Director of Nursing (DON), the DON stated weight loss was a change of condition. The DON stated significant weight loss was 5% weight loss or weight gain in one month or 10% weight loss or weight gain in 6 months. The DON stated the physician should have been informed of planned and unplanned weight loss. The DON stated the standard of practice was for the licensed nurses to notify the physician of the weight loss within the shift or endorsed to the next shift to notify the physician. The DON stated there was going to be a delay in treatment for weight loss when the physician was not notified. During a record review of the facility's P&P titled, Change in a Resident's Condition or Status, revised 2/2021, the policy indicated the nurse will notify the resident's attending physician or physician on call when there has been a significant change in the resident's physical/emotional/mental condition. Notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status.

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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** 45456 Based on observation, interview, and record review, the facility failed to maintain confidentiality of the resident's electronic health record (EHR) for one (1) of 22 sampled residents (Resident 45) by failing to turn off the computer screen and leaving it unattended, exposing the resident's EHR which included the resident's medical condition, list of medications, and other information regarding resident care to others not authorized to view. This deficient practice had the potential to result in the violation of Resident 45's privacy and confidentiality. Findings: During a review of Resident 45's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses which included Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), benign prostatic hyperplasia (BPH, also known as an enlarged prostate, is a noncancerous condition in which the prostate gland becomes larger than normal), and insomnia (a common sleep disorder that can make it hard to fall asleep or stay asleep) During a review of Resident 45's Minimum Data Set (MDS, a federally mandated assessment tool), dated 8/27/2024, the MDS indicated Resident 45 was assessed to have moderately impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 45 was assessed to be needing substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) in toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, roll left and right, toilet transfer, tub/shower transfer, and walk 10-150 feet. During observation in front of Resident 45's room on 11/6/2024 at 11:02 AM, Licensed Vocational Nurse 1 (LVN 1) went inside Resident 45's room. LVN 1 did not turn off the computer monitor on top of the medication cart which was parked along the hallway where other residents and/ or facility staff were passing by. During a concurrent observation and interview with LVN 1 on 11/6/2024 at 11:08 AM, LVN 1 was observed leaving Resident 45's room and proceeded to use the computer on top of the medication cart after administering medication to Resident 45. LVN 1 stated, I should have closed the chart monitor (computer monitor) for Residents 45's privacy. It is important to turn off computer because of Health Insurance Portability and Accountability Act (HIPAA- a federal law that protects sensitive health information from disclosure without the patient's consent) and to protect the privacy of Resident 45's medical record. During an interview with LVN 2 on 11/6/2024 at 11:25 AM, LVN 2 stated, the licensed nurses must ensure that the staff close the EHR/ computer monitor on the top of the medication cart to prevent exposure of residents' information. LVN 2 stated it is the residents' rights not to have the resident's health information exposed to others. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Confidentiality of Information and Personal Privacy, revised on 10/2017, the P&P indicated the facility will protect and safeguard resident confidentiality and personal privacy. The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records. Access to resident personal and medical records will be limited to authorized staff and business associates.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on interview and record review, the facility failed to provide Restorative Nursing Services (a program available in nursing homes to help residents maintain any progress made during therapy treatments, enabling them to achieve their highest practicable level of functioning) as ordered by the physician to increase, prevent, or maintain range of motion (ROM, full movement potential of a joint) for one of three sampled residents (Resident 2). This deficient practice placed Resident 2 at risk for decline in physical functions and developing contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) in the extremities (a limb of the body, such as the arm or leg) for not receiving the ordered exercises. Findings: During a review of Resident 2's Admission Record, the record indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of chronic obstructive pulmonary disease (COPD, disease that causes obstructed airflow from the lungs), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and heart failure (a lifelong condition in which the heart muscle cannot pump enough blood to meet the body's needs for blood and oxygen). During a review of Resident 2's Physician's Order, dated 11/16/2023, the record indicated RNA for bilateral upper extremities (BUE, both arms from shoulder to hands) / bilateral lower extremities (BLE, both legs from hip to foot) active range of motion (AROM, the ROM that can be achieved when opposing muscles contract and relax, resulting in joint movement) five (5) times a week as tolerated. During a review of Resident 2's Restorative Nursing Assistant (RNA) Daily Charting, the record indicated Resident 2 received RNA services for BUE and BLE AROM as tolerated as follows for the month of September 2024. - Week 1: 11/3/2024, 11/5/2024, and 11/6/2024 - Week 2: 11/10/2024, 11/12/2024, and 11/13/2024 - Week 3: 11/17/2024, 11/19/2024, and 11/20/2024 - Week 4: 11/24/2024, 11/26/2024, and 11/27/2024. During a review of Resident 2's RNA Daily Charting, the record indicated Resident 2 received RNA services for BUE and BLE AROM as tolerated as follows for the month of October: - Week 1: 10/1/2024, 10/3/2024, 10/4/2024 - Week 2: 10/8/2024, 10/10/2024, 10/11/2024 (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Week 3: 10/15/2024, 10/17/2024, 10/18/2024 - Week 4: 10/22/2024, 10/24/2024, 10/25/2024 - Week 5: 10/29/2024, 10/31/2024. During a review of Resident 2's RNA Daily Charting, the record indicated Resident 2 received RNA services for BUE and BLE AROM as tolerated as follows for the month of November: - Week 1: 11/1/2024 - Week 2: 11/3/2024, 11/5/2024, 11/7/2024. During a review of Resident 2's Minimum Data Set (MDS, a federally mandated resident assessment and tool), dated 9/13/2024, the record indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was intact. The MDS indicated Resident 2 required substantial/maximal assistance (helper does more than half the effort) for upper and lower body dressing, personal hygiene, roll left and right, sit to lying, and lying to sitting on side of bed. The MDS also indicated Resident 2 had three days of active range of motion for the restorative program performed. During a review of Resident 2's activity of daily living (ADL) function rehabilitation care plan, dated 9/25/2024, the care plan indicated staff interventions were to encourage independence in ADLs by providing cues and monitor for continued independence, allow to participate with ADLs to tolerance, and RNA for AROM to BUE/BLE five times a week as tolerated. During a concurrent review of Resident 2's care plan, physician order, RNA Daily Charting, and Resident 2's electronic medical record and interview on 11/7/2024 at 8:34 AM with the Care Plan Coordinator (CPC), CPC stated Resident 2's care plan indicated Resident 2 had RNA services five times a week for upper and lower extremities as tolerated. CPC also stated the physician had ordered RNA services to be done five times per week. CPC stated RNA services were only being done three (3) times a week and not 5 times a week per physician order. CPC stated there were no notes indicating Resident 2's refusal of RNA services for the missing two times per week for RNA services. During a concurrent review of Resident 2's RNA Daily Charting interview on 11/7/2024 at 9:12 AM with Restorative Nursing Aide 1 (RNA 1), RNA 1 stated Resident 2 received RNA services 5 times a week. RNA 1 stated Resident 2 would refuse to complete RNA services once a month. RNA 1 stated Resident 2's refusals for RNA services should be documented on the chart. RNA 1 stated she did not see any notes for Resident 2 refusing RNA services. RNA 1 stated it was important for Resident 2 to receive her RNA services to prevent her from becoming contracted since Resident 2 spent most of her time in bed and refused to get out of bed. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent review of Resident 2's Physician's Order Summary on 11/7/2024 at 9:52 AM with Director of Occupational Therapy (DOT), DOT stated the physician had ordered RNA services for upper and lower extremity exercises and range of motion. DOT stated the physician ordered RNA services 5 times throughout the week to maintain functional status throughout. DOT stated 5 times per week RNA services was recommended for maintenance of general functional status, range of motion, and activity tolerance since Resident 2 generally choose to stay in bed. DOT stated based on the physician's order, the RNA should have followed the physician's order unless the resident refused services which should be documented in the Refused section. During a review of the facility's Policy and Procedure (P&P) titled, Resident Mobility and Range of Motion, revised 7/2017, the policy indicated residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in range of motion. During a record review of the facility's P&P titled, Restorative Nursing Services, revised 7/2017, the policy indicated restorative goals may include, but are not limited to supporting and assisting the resident in participating in the development and implementation of his/her plan of care.

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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 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** 45456 Based on observation, interview and record review, the facility failed to provide interventions to prevent accidents (any unexpected or unintentional incident, which results or may result in injury or illness) for three (3) of 3 sampled residents (Resident 61, 29, and 24) by failing to: 1. Ensure a functional bed sensor pad (alerting device intended to monitor a resident's movement) for Resident 61's use, as indicated on the physician's order and failed to ensure resident's call light was within reach, as indicated on the fall care plan. 2. Identify and eliminate all foreseeable accident hazards and include care plan interventions to address underlying cause of fall for Resident 24 who had a history of falls on 5/25/2024, 7/13/2024, 8/30/2024, and 9/27/2024. 3. Ensure Resident 29's sensor pad alarm was properly positioned and turned on and worked at all times. These deficient practices placed Residents 61, 24, and 29 at risk for falls and injury which had the potential to result in serious consequences like fractures (break in the bone), hospitalization , and death. Findings: 1. During a review of Resident 61's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses which included heart failure (a lifelong condition in which the heart muscle cannot pump enough blood to meet the body needs for blood and oxygen), paroxysmal atrial fibrillation (PAF, is a type of irregular heartbeat, or arrhythmia [an irregular heartbeat, or a problem with the rate or rhythm of your heart], that occurs in brief episodes that last less than seven days), muscle weakness, and unsteadiness on feet. During a review of Resident 61's Minimum Data Set (MDS, a federally mandated assessment tool), dated 11/4/2024, the MDS indicated Resident 61 had severe cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 61 needed partial/ moderate assistance (helper does less than half the effort, helper lifts, hold, or supports trunk or limbs but provides less than half the effort) with toileting hygiene, sit to stand, chair/bed -to chair transfer, toilet transfer. Resident 61 also needed supervision or touching assistance (helper provides verbal cues and/or touching/ steadying and/or contact guard assistance as resident completes activity) with oral hygiene, roll left and right, sit to lying, lying to sitting on side of the bed, and walk 10-150 feet. During a review of Resident 61's Physician's Orders, dated 10/8/2024, the Physician's Order indicated bed sensor pad at all times every shift for unsafe behavior manifested by getting up unassisted and record number of episodes. (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 61's Fall Care Plan (CP), dated 8/13/2024, the CP indicated Resident 61 was at risk for self-injury from fall related to medical conditions, sensory alterations, balance, gait, assistive devices, cognition, mood/behavior, safety awareness, compliance, and medications. Goal indicated will follow safety suggestions and limitation with supervision and verbal reminders for better control of risk factors. Interventions included: Ensure that adaptive devices: walker are within reach. Encourage and assist placement of proper non-skid footwear. Observe for non-verbal signs of restlessness that may precipitate movement and attempts to stand/walk unattended. Observe for unsteady /unsafe transfer or ambulation and provide stand by or balance support as needed. Keep call light within reach at all times. Answer promptly and notify Resident 61 that help is coming. During an observation in Resident 61's Room on 11/7/2024 at 11:28 AM, Resident 61's call light was not within her reach. The call light was observed on the top drawer of the bedside table which was on the opposite side of the bed. The pad alarm machine box was hanging on the right side of the bed. The pad alarm did not make a sound/alarm when Resident 61 was trying to get out of her bed multiple times. During a concurrent observation in Resident 61's room and interview with Certified Nurse Assistant 1 (CNA 1) on 11/7/2024 at 11:29 AM, CNA 1 observed and stated the pad alarm did not make a sound /alarm when Resident 61 was observed trying to get out of her bed. CNA 1 stated Resident 61's call light was not within her reach and was placed on the top drawer of the bedside table which was on the opposite side of the bed. During a concurrent observation and interview with CNA 1 on 11/7/2024 at 11:32 AM, CNA 1 stated the pad alarm was placed on the left side of the bed and should have been placed in the middle of the bed where Resident 61was laying down for it to work. During an interview with CNA 1 on 11/7/2024 at 11:34 AM, CNA 1 stated, it was important for the pad alarm to make a sound/alarm to alert the staff , prevent Resident 61 might end up from falling. During a review of facility's policy and procedure (P&P) titled, Safety and Supervision of Residents revised on 7/2017, the P&P indicated the care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. It also indicated to reduce accidents risks and hazards shall include the following: ensuring that interventions are implemented. (continued on next page)

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Atherton Baptist Home	214 South Atlantic Blvd. Alhambra, CA 91801

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's P&P titled, Falls and Managing Fall Risk, revised on 3/2018, the P&P indicated position-change alarms will not be used as the primary or sole intervention to prevent falls, but rather will be used to assist the staff in identifying patterns and routines of the resident. The use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner. 46919 2. During a review of Resident 24's Admission Record, the Admission Record indicated Resident 24 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included muscle weakness, difficulty in walking, benign paroxysmal vertigo unspecified ear (a common inner ear disorder that can cause vertigo or a false sense of spinning or movement), and history of falling. During a review of Resident 24's MDS, dated [DATE], the MDS indicated Resident 24 was assessed having moderately impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 24 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene, shower/bathe self, upper/lower body dressing, and putting on/taking of footwear. Resident 24 also required partial moderate assistance with sit to stand, chair/bed-to-chair transfer (ability to transfer to and from a bed to a chair), toilet transfer, and walking 10 feet (ft- unit of measurement). The MDS indicated Resident 24 had a one (1) fall with no injury since the last prior assessment on 6/6/2024. During a review of Resident 24's Morse Fall Scale Assessment form, dated 9/27/2024, the form indicated a total fall risk score of 65 (a score of 51 or above indicated high risk for falls). During a review of Resident 24's Interdisciplinary (IDT- a group of healthcare professionals who work together to help people receive the care they need) Note, dated 5/25/2024, the IDT Note indicated, At 6:15 AM, heard sensor pad. Entered into resident's room and found resident on the floor on his left side in front of his recliner. Certified Nursing Assistant (CNA) put resident in his recliner .color pale with abrasion (when the surface layer of the skin has been broken) to right cheek measuring 0.3 centimeter (cm-unit of measurement) x 0.3 cm color red and skin tear to right eyebrow area measuring 0.2 cm x 0.2 cm with blood drainage. During a review of Resident 24's IDT Note, dated 7/13/2024, the IDT Note indicated, At 12:10 PM, heard sensor pad alarm in room [ROOM NUMBER], 2 staff check and found Resident on the floor in side lying position in front of bathroom .Resident was noted with laceration (a deep cut or tear in the skin) in back of head size 4 cm x 1 cm, with small amount of bleeding .complain of (c/o) pain 5/10 .asked Resident what happened Resident, Resident stated 'I fell , I don't know how. Called Medical Doctor 1 (MD 1) and reported the incident with new order to transfer to General Acute Care Hospital (GACH) via regular ambulance. During a review of Resident 24's IDT Note, dated 8/30/2024, the IDT Note indicated, At 9:15 AM, summoned to room [ROOM NUMBER] by CNA, observed resident on the floor, sitting position, in front of the bed with wheelchair (w/c) behind him, alert, and verbally responsive .Upon investigation, resident stated he slid from his w/c resulting for him to sit on the floor .CNA reported that heard an alarm and when went to the resident's room, observed resident on the floor. Per CNA, he saw resident sitting in a w/c wheeling himself on the station. Sensor pad was on and functioning well. (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 24's IDT Note, dated 9/24/2024, the IDT Note indicated, At 11:33 AM, I heard sensor pad alarm going off. When I enter Res. room notice res. sitting on the floor at the end of the footrest of the recliner chair, notice call light on his lap. Sensor pad alarm turn off alarm and working properly. When I asked Res. what happen, Res. stated I slide from the recliner chair when I was trying to stand up to reach for my W/C he stated this recliner is very tricky. During an interview with Resident 24, on 11/4/2024, at 3:48 PM, Resident 24 stated he was admitted to the facility after sustaining a fall. Resident 24 stated he had fallen four times in the facility. Resident 24 stated he fell by the bathroom but could not remember why he fell . During an interview with Licensed Vocational Nurse 1 (LVN 1), on 11/6/2024, at 11:40 AM, LVN 1 stated Resident 24 had a history of falls prior to admission. LVN 1 stated Resident 24 has fallen four (4) times in the facility since admission. LVN 1 stated Resident 24 fell in front of his recliner the first time he fell on [DATE]. LVN 1 stated Resident 24 was found on the floor in a side lying position in front of the bathroom the second time he fell on [DATE]. LVN 1 stated Resident 24 slid off his wheelchair and was found sitting on the floor in front of his bed the third time he fell on [DATE]. LVN 1 stated Resident 24 was found sitting on the floor after he slid from his recliner when he tried to reach for his wheelchair the fourth time he fell on [DATE]. LVN 1 stated the sensor pad alarm alerted staff each time Resident 24's fell . LVN 1 stated the interventions in the care plan should be resident-centered. LVN 1 stated it was the responsibility of the licensed nurses and the Care Plan Coordinator (CPC) to revise the care plan. LVN 1 stated the care plan should be reviewed by the CPC to assess if the interventions were effective or if it needed to be updated. During a concurrent review of Resident 24's care plan, dated 5/25/2024, and interview with the CPC on 11/6/2024, at 12 PM, CPC stated the care plan indicated Resident 24 was found on the floor on his left side on 5/25/2024. CPC stated Resident 24's care plan intervention did not and should have indicated interventions such as specific safety measures related to the risk and cause of the fall to prevent fall reoccurrence. During a concurrent review of Resident 24's care plan, dated 8/30/2024, and interview with the CPC on 11/6/2024, at 12:02 PM, CPC stated the care plan indicated Resident 24 slid from the wheelchair during self-propel on 8/30/2024. CPC stated Resident 24's care plan intervention did not and should have indicated interventions to include wheelchair safety during self-propel and transfer to prevent fall reoccurrence. During a concurrent review of Resident 24's care plan, dated 9/27/2024, and interview with the CPC on 11/6/2024, at 12:04 PM, CPC stated the care plan indicated Resident 24 was noted sitting on the floor in his own room on 9/27/2024. CPC stated the care plan problem did not indicate Resident 24 was found at the footrest of the recliner chair. CPC stated the care plan interventions did not and should have indicated safety measures when Resident 24 tries to stand up from recliner to transfer to the wheelchair and when sitting on the recliner to prevent fall reoccurrence. (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 interview with the CPC and record review, on 11/6/2024, at 12:06 PM, Resident 24's care plan titled, Falls, was reviewed. The CPC stated Resident 24's care plan did not include interventions on wheelchair safety or how to prevent Resident 24 from sliding off the recliner. The CPC stated the facility staff should be proactive in preventing falls for Resident 24. The CPC stated Resident 24's care plan for falls should be specific to Resident 24's fall risk because he tends to slip and fall in his room. The CPC stated the care plan interventions should be reassessed if not effective to meet the goal. During an interview with the Director of Nursing (DON), on 11/7/2024, at 10:44 AM, the DON stated Resident 24's had a history of falls and hi specific needs to prevent falls should be included in the care plan for prevent falls from recurring. 3. During a review of Resident 29's Admission Record, the Admission Record indicated Resident 29 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia (a brain disorder that results in memory loss, poor judgment, and confusion), history of falling, and unsteadiness on feet. During a review of Resident 29's Care Plan titled, Falls, dated 7/26/2024, the care plan indicated Resident 29 needed supervision to substantial assistance with activities of daily living (ADLs). It indicated Resident 29 ambulates using a walker with staff, has impaired cognition, and has poor safety awareness. It indicated Resident 29 needs cueing and reminder for safe functioning related to dementia, hypertension (HTN- high blood pressure), PAD, CKD, hyperlipidemia, osteoporosis, macular degeneration, edema, osteoarthritis (OA- a progressive disorder of the joints, caused by a gradual loss of cartilage), Vitamin B deficiency, and CAD. The care plan indicated the following interventions to minimize risk of fall or injury daily: Sensor pad alert as ordered. Explain risks and benefits to resident and representative. Bed and chair sensor pad alarm at all times. Monitor proper placement and function of sensor pad every (q) shift. During a review of Resident 29's MDS, dated [DATE], the MDS indicated Resident 29 was assessed having severely impaired cognitive skills for daily decision making. Resident 29 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shoer/bathe self, and lower body dressing. Resident 29 required partial/moderate assistance with sit to stand, chair/bed-to-chair transfer, and toilet transfer. Resident 29 required supervision or touching assistance with walking 10 feet and walking 50 feet with two turns. The MDS indicated Resident 29 had a one (1) fall with injury (except major) since the last prior assessment on 7/8/2024. During a review of Resident 29's Physician's Orders form, dated 11/6/2024, the Physician's Orders form indicated an order, with a start date of 6/5/2024, for bed and chair sensor pad alarm at all times- every shift for unsafe behavior manifested by (m/b) getting up unassisted and record number of episodes. During a review of Resident 29's Morse Fall Scale Assessment form, dated 10/21/2024, the form indicated a total fall risk score of 70 (a score of 51 or above indicated high risk for falls). (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 of Resident 29 and interview with an unidentified staff member, on 11/4/2024, at 10:55 AM, Resident 29 was observed sitting on a chair outside her room. Resident 29 had a white cord hanging from her chair. The unidentified staff member walked by and stated the white cord was the sensor pad alarm. Resident 29 attempted to stand up and the sensor pad alarm did not go off. The unidentified staff member checked the white box that was connected to the sensor pad alarm and stated the sensor pad was not turned on. During a concurrent observation of Resident 29 and interview LVN 1 on 11/6/2024, at 3:41 PM, Resident 29 was observed sitting on a chair outside her room. Resident 29 was observed shifting and attempting to stand up from her chair. LVN 1 stated Resident 29 always sits on the chair outside her room. LVN 1 stated the chair had a sensor pad alarm because Resident 29 had a history of falls and tends to stand up without assistance from staff. LVN 1 observed Resident 29 attempt to stand up from the chair. The sensor pad alarm did not go off. LVN 1 checked the white box connected to the sensor pad alarm and stated the sensor pad alarm was off. LVN 1 stated the sensor pad alarm should always be on when Resident 29 is sitting on her chair. LVN 1 observed Resident 29 attempt to stand up from the chair again. The sensor pad alarm did not go off. LVN 1 checked the white box and stated the sensor pad alarm was on but did not know why the alarm did not go off. LVN 1 asked Resident 29 to stand up and repositioned the sensor pad alarm. LVN 1 asked Resident 29 to stand up again and the sensor alarm pad went off. LVN 1 stated the sensor pad needs to be completely underneath Resident 29 for the alarm to go off when Resident 29 stands. LVN 1 stated the sensor pad alarm was important because it notifies the staff when Resident 29 moves and tries to get up from her seat without assistance. LVN 1 stated it was important for Resident 29's sensor pad alarm for the safety of the Resident and to prevent falls. LVN 1 stated it was the responsibility of the CNAs and the Charge Nurses (CN) to make sure the sensor pad alarm was on and in the right position. During an interview with the DON, on 11/7/2024, at 11:01 AM, the DON stated the sensor alarm pad needs to always be on to know when the residents need assistance. The DON stated it was important to provide the residents assistance in a timely manner to prevent falls in the facility. The DON stated it was the responsibility of the CNAs and the CNs to make sure the sensor pad alarms are turned on. During a review of the facility's policy and procedure (P&P), titled, Falls and Fall Risk, Managing, revised on 3/2018, the P&P indicated the following: Based on previous evaluation and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The staff, with the input of the attending physician, will implement a Resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each Resident at risk or with a history of falls. Examples of initial approaches might include exercise and balance training, rearrangement of room furniture, improving footwear, changing the lighting, etc. If falling recurs despite initial interventions, stall will implement additional or different interventions, or indicate why the current approach remains relevant. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	If underlying causes cannot be readily identified or corrected, staff will try various interventions, cased on assessment of the nature of category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. In conjunction with the attending physician, staff will identify and implement relevant interventions (e.g. hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling. Position-change alarms will not be used as the primary or sole intervention to prevent falls, but rather will be used to assist the staff in identifying patterns and routines of the Resident. The use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner. If the Resident continues to fall, stall will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified.

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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** 46919 Based on interview and record review the facility failed to ensure the physician addressed the medication regimen review (MRR/Drug Regimen Review - a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) to indicate a reason for disagreeing with the pharmacist recommendation for gradual dose reduction (GDR- the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) of Ativan (lorazepam- a medication used for anxiety [feeling of fear, dread, or uneasiness that can be mild or severe]) for one of 22 sampled residents (Resident 17) on 10/25/2024. This deficient practice had the potential to result in adverse medication outcome for potential unnecessary medications to Resident 17. Findings: During a review of Resident 17's Admission Record, the Admission Record indicated Resident 17 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included major depressive disorder (MDD- a mood disorder that causes a persistent feeling of sadness and loss of interest), unspecified pain, and anxiety disorder (fear characterized by behavioral disturbances). During a review of Resident 17's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 9/6/2024, the MDS indicated Resident 17 was assessed having severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 17 required setup or clean-up assistance with eating. Resident 17 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower/bathe self, lower body dressing, and toilet transfer. Resident 17 did not have any mood or behavioral symptoms. During a review of Resident 17's Physician's Orders form, dated 11/7/2024, the Physician's Orders form indicated an order, with a start date of 10/23/2024, for Ativan 0.5 milligrams (mg- unit of measurement) tablet (tab)- 1/2 tab=0.25 mg by mouth (po) every (q) evening at 1 PM for anxiety manifested by (m/b) restlessness. The Physician's Orders also indicated an order, with a start date of 10/25/2024, for Ativan 1 mg tab- 1.5 mg by mouth every evening for anxiety disorder unspecified m/b restlessness. During a review of Resident 17's Care Plan titled, Psychotropic Drugs (medications that impact the brain and nervous system's chemical makeup to treat mental illnesses), dated 9/30/2024, the care plan indicated Resident 17 had the potential for drug related complications associated with the use of psychotropic medication to manage mood/behavior related to depression, psychosis (a mental state where a person has difficulty distinguishing reality from what is real), anxiety, and impulse disorder (a condition that makes it difficult to control actions or reactions). The care plan indicated an intervention to attempt/initiate gradual dose reduction as recommended by pharmacy consultant and as ordered by MD. (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 review of Resident 17's Interdisciplinary (IDT- a coordinated group of experts from different fields) Note, dated 10/25/2024, the IDT Note indicated, Informed Physician Assistant 1 (PA 1) regarding pharmacy recommendation, he made new orders to change current dosage of Ativan 1.5 mg q 7PM to Ativan 1.5 mg q 6PM and change mirtazapine (a drug used to treat depression) 45 mg to mirtazapine 30mg q hour of sleep (hs). Informed Medical Doctor 1 (MD 1) with the orders and agreed to continue with it. Daughter 1 (DTR 1) is aware and agreed. Noted new orders and carried out. Endorsed to oncoming shift. During a concurrent interview and record review with the Director of Nursing (DON), on 11/7/2024, at 11:17 AM, Resident 17's Note to Attending Physician/Prescriber form, printed on 10/18/2024, was reviewed. The DON stated PC 1's drug recommendation on the Note to Attending Physician/Prescriber form indicated Resident 17 takes lorazepam 0.25 mg PM (4:00 PM) and 1.5 mg q PM (7:00 PM). Please consider a dose reduction, perhaps decreasing the 7PM dose to 1mg. If a gradual dose reduction is contraindicated, please specify why. During the same interview with the DON on 11/7/2024, at 11:17 AM, facility's policy and procedure (P&P), titled, Consultant Pharmacist Reports, dated 12/2016, was reviewed. The DON stated the P&P indicated, Recommendations are acted upon and documented by the facility staff and or the prescriber. Physician accepts and acts upon suggestion or rejects and provides an explanation for disagreeing by the next physician date. The DON stated PA 1 and MD were notified of PC 1's drug recommendation report as soon as it was received. The DON stated Resident 17's family was also informed regarding PC 1's recommendation and requested for only the mirtazapine dose to be decreased. The DON stated PA 1 decreased Resident 17's mirtazapine from 45 mg to 30 mg and changed the Ativan administration time from 7PM to 6PM but did not decrease the Ativan dose as recommended by PC 1. The DON stated the MD sees residents in the facility every Wednesday but does not know why the MD did not indicate the reason why the drug recommendation was not accepted. The DON stated there was no documented explanation from the MD for not decreasing Resident 17's Ativan dose from 1.5 mg to 1mg.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on interview and record review, the facility failed to ensure the drug regimen for one (1) of five sampled residents (Resident 17) was free from unnecessary drugs by failing to assess the continued need for Tylenol (acetaminophen- used relieve mild to moderate pain from headaches, muscle aches, and to reduce fever) after it was not administered as needed for pain for more than ninety (90) days. This deficient practice had the potential for Resident 17 to suffer adverse reactions from unnecessary drug including bleeding easily and bruising. Findings: During a review of Resident 17's Admission Record, the Admission record indicated Resident 17 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included major depressive disorder (MDD- a mood disorder that causes a persistent feeling of sadness and loss of interest), unspecified pain, and anxiety disorder (fear characterized by behavioral disturbances). During a review of Resident 17's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 9/6/2024, the MDS indicated Resident 17 was assessed having severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 17 required setup or clean-up assistance with eating. Resident 17 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower/bathe self, lower body dressing, and toilet transfer. Resident 17 did not receive as needed pain medications as needed and did not have the presence of pain. During a review of Resident 17's Physician's Orders, dated 11/7/2024, the Physician's Orders indicated an order, with a start date of 4/10/2024, for Tylenol Extra Strength 500 milligram (mg- unit of measurement) 1 tablet (tab) by mouth twice daily for pain management. Resident 17 also had an order, with a start date of 10/27/2020, for Tylenol Extra Strength 500 mg 1 tab by mouth every four hours for pain as needed, last dose 4/16/2024. During a review of Resident 17's care plan During a review of Resident 17's Physician's Orders, dated 11/7/2024, the Physician's Orders indicated an order, with a start date of 6/18/2019, to assess pain level every shift: Pain scale: 0=no pain 1-3= mild pain 4-7= moderate pain (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8-10= severe pain During a concurrent interview and record review with the Director of Nursing (DON), on 11/7/2024, at 3:56 PM, Resident 17's Medication Record from 8/2024, 9/2024, 10/2024, and 11/2024, was reviewed. The DON stated Resident 17 was assessed for pain every four (4) hours. The DON stated Resident 17 was assessed to have a pain level of 0 from 8/2024, 9/2024, 10/2024, and 11/2024. During the same concurrent interview and record review with DON, on 11/7/2024, at 3:56 PM, the DON stated Resident 17's Medication Record indicated Resident 17 did not receive any Tylenol Extra Strength 500 mg 1 tab by mouth every four hours as needed for pain from 8/2024, 9/2024, 10/2024, and 11/2024. The DON stated Resident 17's pain was managed by the Tylenol dose she received twice daily. The DON stated Resident 17's order for Tylenol Extra Strength 500 mg 1 tab by mouth every four hours as needed for pain medication was considered unnecessary if it has not been administered to Resident 17 for more than 90 days. During a review of the facility's policy and procedure (P&P), titled, Medication Utilization and Prescribing-Clinical Protocol, revised on 7/2016, the P&P indicated the following: The physician and staff will review the rationale for existing medications that lack a clear indication or are being used intermittently on a PRN (as needed) basis. The physician and staff will adjust existing medications based on their efficacy and the continued presence of relevant conditions and risks. The staff and physician will periodically re-evaluate the conditions and symptoms for which each resident is receiving medications to ensure that the medication and dosage are still relevant and are not causing undesired complications.

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	555272	A. Building B. Wing	11/07/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45456 Based on observation, interview, and record review, the facility failed to ensure safe provision of pharmaceutical services by failing to properly label the medications with the date opened of one (1) of 8 sampled residents as indicated on the facility policy. This deficient practice had the potential for adverse reaction if these improperly labeled medications were administered to Resident 45. Findings: During a review of Resident 45's Admission Record indicated the resident was admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses which included Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), benign prostatic hyperplasia (BPH, also known as an enlarged prostate, is a noncancerous condition in which the prostate gland becomes larger than normal), and insomnia (a common sleep disorder that can make it hard to fall asleep or stay asleep) During a review of Resident 45's Minimum Data Set (MDS, a federally mandated assessment tool), dated 8/27/2024, the MDS indicated Resident 45 was assessed to have moderately impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 45 was assessed to be needing substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) in toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, roll left and right, toilet transfer, tub/shower transfer, and walk 10-150 feet. During a review of Resident 45's Physician's Order dated 6/30/2024 indicated carbidopa 25 milligrams (mg, unit of measure) - levodopa 100mg (is commonly used to treat Parkinson's disease). Take 1 tab by mouth 3 times a day for Parkinson's disease. During an observation of Resident 45's medication administration with Licensed Vocational Nurse 1 (LVN 1) on 11/6/2024 at 11 AM, there was no label of date opened on the medication bottle of carbidopa- levodopa was observed. During a concurrent observation and interview with LVN 1 on, 11/6/2024 at 11:05 AM, LVN 1 observed Resident 45's medication bottle carbidopa- levodopa has no date open written on the medication container. LVN 1 stated, the facility should have labeled the medicine bottle with date the bottle was opened/ firs used. LVN 1 stated If we are the one who opened the medicine bottle, we should have written down the date open on the container. During an interview with LVN 1 on 11/12/2024 at 11:06 AM, LVN 1 stated, it is important to write or label the medicine container with the date it was opened, and the reason is for the staff to find out the date that the medication was received and to account the number/ amount of medications inside the container. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN 2 on 11/6/2024 at 11:21 AM, LVN 2 stated, licensed nurse counts the pills inside the medicine bottle and document in a log if the medication is from an outside pharmacy including all over- the - counter (OTC) provided by family. LVN 2 stated, We do not count the medications if the medicine container came in sealed from the facility's pharmacy. We log it on the logbook. The staff who started to administer the medication to the resident and opened the medicine bottle should write the date opened on the medication container. During an interview with LVN 2 on 11/6/2024 at 11:22 AM, LVN 2 stated, It is important to label the medication container to make sure that medications were given as directed, to prevent missing medications, and account every pill inside the medication bottle. During a review of the facility's policy and procedure titled, Administering Medications revised 4/2019, indicated the expiration /beyond use date on the medication label is checked prior to administering. The policy also indicated when opening a multi-dose container, the date opened is recorded on the container.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on observation, interview and record review, the facility failed to provide food that accommodated food preferences for one (1) of two sampled residents (Resident 40). This deficient practice had the potential to result in decreased meal intake and can lead to weight loss and malnutrition. Findings: During a review of Resident 40's Admission Record, the Admission Record indicated Resident 40 was admitted to the facility on [DATE] with diagnoses that included unspecified atrial fibrillation (afib- irregular and often very fast heartbeat that can lead to blood clots in the heart), heart failure (a serious condition in which the heart does not pump blood as efficiently as it should), and essential hypertension (high blood pressure). During a review of Resident 40's History and Physical examination (H&P), dated 5/16/2024, the H&P indicated Resident 40 did not have the capacity to understand and make decisions. During a review of Resident 40's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 8/16/2024, the MDS indicated Resident 40 was assessed having intact memory and cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 40 required setup or clean-up assistance with eating and oral hygiene. Resident 40 was independent (completes the activity by themself with no assistance from a helper) with sit to stand and toilet transfer. During a review of Resident 40's Physician's Orders, dated 11/6/2024, the Physician's Orders indicated an order, with a start date of 7/1/2021 for regular diet; okay to substitute to mechanical soft () three times a day. During a review of Resident 40's care plan titled, Nutrition. dated 8/28/2024, the care plan indicated Resident 40 had the potential for alteration in nutrition and the intervention indicated to offer alternative meal when available if Resident 40 does not like what is being served and order food, but cannot decide that to eat. The care plan also indicated Resident 40 had the potential for weight loss due to (d/t) poor appetite and the intervention indicated to provide diet as ordered. During an observation of Resident 40, in the dining room, on 11/4/2024, at 12:04 PM, Resident 40 was sitting on the dining table with green tea, water and apple juice in front of her. Certified Nursing Assistant 3 (CNA 3) placed Resident 40's food tray in front of Resident 40. Resident 40's food tray included a dinner roll, sweet potatoes, green beans, ground chicken arrabiata, and chopped lemon dill tilapia. CNA 3 walked back to the serving table and returned to Resident 40 with a bowl of chicken congee and chicken noodle soup. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 40's tray card (a card that contains information about a resident's meal service, including allergy, dislikes, preferences, standing orders (written instructions that specifies dietary guidelines for residents who meet certain criteria), special utensil requirements), dated 11/4/2024 lunch, the tray card indicated a standing order for Jello, 4 fluid ounce (fl oz- unit of measurement) apple juice, congee (rice porridge), 4 fl oz hot tea (green tea), 4 ounce (oz- unit of measurement) soy milk, and 1/4 cup white rice. During a concurrent interview and review with the Director of Staff Development (DSD), on 11/4/2024, at 12:40 PM, Resident 40's tray card for lunch was reviewed. The DSD stated Resident 40 was not served white rice, soy milk, and Jello with the rest of her meal. During an interview with CNA 3, on 11/9/2024, at 10:33 AM, CNA 3 stated Resident 40 wrote down her food preference in the morning of 11/4/2024. CNA 3 stated she did not read Resident 40's lunch tray card on 11/4/2024. CNA 3 stated she did not check if there were missing food items on Resident 40's food tray before giving it to Resident 40. CNA 3 stated it was important that Resident 40 is provided with the food requested to eat because of her history of weight loss. During an interview with the Director of Nursing (DON), on 11/7/2024, at 10:41 AM, the DON stated the food preferences of the residents should always be followed for the residents' dignity. Furthermore, the DON stated residents with a history of weight loss should be provided with food that they prefer to encourage them to eat. During a review of the facility's policy and procedure (P&P), titled, Resident Dining Profile and Food Preferences, revised on 1/2024, the P&P indicated Residents on a modified/therapeutic diet are offered similar choices as the main meal in compliance with their diet restrictions. The P&P indicated food substitutions are provided when the Resident chooses not to consume meal items served and should be of equal nutritional value to the planned menu item. The P&P further indicated individual Resident choice at or between meals takes precedence over recorded preferences unless the requested item contains a recorded food allergen or is not consistent with the diet order. Reasonable accommodations regarding meal planning and need for recipes and purchased items outside the scope of the planned menu will be made for those residents with extensive dislikes, food allergies and/or special dietary needs. During a review of the facility's P&P, titled, Quality of Life-Accommodation of Needs, revised on 11/2010, the P&P indicated the facility's environment and staff behaviors are directed toward assisting the Resident in maintaining and/or achieving independent functioning, dignity and well-being. The P&P also indicated, The residents individual needs and preferences shall be accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered. During a review of the facility's P&P, titled, Resident Rights, revised on 2/2021, the P&P indicated Employees shall treat all residents with kindness, respect, and dignity. The P&P indicated Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to a dignified existence and to be treated with respect, kindness, and dignity.

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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. 48143 Based on observation, interview, and record review, the facility failed to label food items in the kitchen with item name, opened and expiration date as indicated in the facility's policy and procedure. This deficient practice had the potential to result in pathogen (germ) exposure to residents, which could place the residents at risk for developing foodborne illness such as food poisoning with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever and can lead to other serious medical complications and hospitalization . Findings: During a concurrent observation and interview on 11/7/2024 at 7:49 AM with dietary supervisor (DS) in the walk-in refrigerator of the main kitchen, the following were observed: a. Four trays of marinated fish fillet have no labels for the name of the food item, date, and time it was prepared and no label of use-by date. b. Three trays of prepared Jello have no lids to cover the trays of the Jello, there were no labels for the name of the food item, date, and time it was prepared and no label of use-by date. c. One loaf of banana bread in the metal container has no wrapping, no lid, and there was no label for the name of the food item, date, and time of prepare and the use by date. DS stated all the food trays should always be labeled with the food item name, preparation date and time, and the use by date for each food item. DS stated all the ready to eat food items are supposed to be covered with lids or shrink wrap (transparent plastic film used to cover/ enclose food items) to prevent food contaminations. During a concurrent observation and interview on 11/7/2024 at 8:09 AM with dietary service director (DD) and DS in the walk-in freezer, the following were found: a. Three (3) bags of frozen meat were randomly sitting on top of two paper boxes, the 3 bags of frozen meat were not labeled with food item name, there were no purchase date, no expiration date and no best use by date. b. Two (2) packages of snap pea not labeled with expiration date. c. Two packages of breakfast waffles not labeled with food item name, and no use by date. d. One bag of cream puffs with no food item name and no expiration date. DD and DS stated all food items were supposed to be labeled with food item name and labeled with the used by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 11/7/2024 at 8:23 AM with DD and DS in the dry food storage area next to the main freezer observed one bag of buttermilk biscuit mix and was not labeled with used by date. During a review of the facility's policy and procedure (P&P) titled, Food and Supply Storage, revised on 1/2024, the P&P indicated all food, non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. The policy and procedure also indicated cover, label and date unused portions and open packages.