

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555273	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/02/2025
NAME OF PROVIDER OR SUPPLIER Manchester Manor Conv Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 837 W. Manchester Ave. Los Angeles, CA 90044	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 48712 Based on observation, interview, and record review, the facility failed to: 1. Ensure the results of their last recertification survey was in a place easily accessible and viewed by residents/the public. This deficient practice had the potential to result in residents/the public not being well informed about the quality-of-care residents receive at the facility. Findings: During a concurrent observation and interview on 2/1/2025 at 8:40 a.m. with Licensed Vocational Nurse (LVN) 5 in the front lobby, the facility's last survey results were not in a place visible to residents/the public. LVN 5 stated family members need to know what kind of facility this is. LVN 5 stated the survey results tell visitors about infractions, strengths, and if there were any major incidents. Family members can receive information about where they are putting their loved ones. LVN 5 stated since the results are not visible, the public doesn't know what is going on inside the facility. LVN 5 found the survey results behind the nurse's station in a non-transparent file rack labeled 11-7 LVN's. LVN 5 stated the file rack was not accessible. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, dated October 2023, the P&P indicated residents have the right to examine survey results.		

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49131 Based on interview, and record review the facility failed to: 1. Ensure one of two residents (Resident 21) had a physician order to transfer out to the hospital. This deficient practice had the potential to result in miscommunication amongst the facility staff and physician. Findings: During a review of Resident 21's Face Sheet, it indicated Resident 21 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included seizures, hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and hemiparalysis (weakness or paralysis on one side of the body). During a review of Resident 21's Minimum Data Set (MDS - a resident assessment tool) dated 10/1/2024, it indicated Resident 21 was cognitively intact (ability to reason, understand, remember, judge, and learn). During a review of Resident 21's Progress Notes dated 6/29/2024 at 8:05 a.m., it stated Resident 21 left the facility to the general acute care hospital (GACH). During a review of Resident 21's Transfer Form dated 6/29/2024, it indicated Resident 21 was transferred to the GACH for abdominal pain. During a concurrent interview and record review on 2/2/2025 at 10:06 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 21's Order Summary was reviewed. LVN 2 stated there were no orders placed to transfer the resident out to the GACH. LVN 1 stated there needs to be an order for that because it is up to the doctor to decide if the resident needs to be transferred out. During a review of the facility's policy and procedure titled, Discharge/Transfer Documentation, dated, 4/22/2002, it indicated when a resident discharge is anticipated, the nurse will obtain an order for discharge from the attending physician.		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49131 Based on interview and record review, the facility failed to: 1. Ensure Resident 21 had a Change in Condition Form completed when they had to be transferred to the general acute care hospital (GACH). This deficient practice had the potential for staff to miss appropriate monitoring and interventions for Resident 21. Findings: During a review of Resident 21's Face Sheet, it indicated Resident 21 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included seizures, hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and hemiparalysis (weakness or paralysis on one side of the body). During a review of Resident 21's Minimum Data Set (MDS - a resident assessment tool) dated 10/1/2024, it indicated Resident 21 was cognitively intact (ability to reason, understand, remember, judge, and learn). During a review of Resident 21's Progress Notes dated 6/29/2024 at 8:05 a.m., it stated Resident 21 left the facility to the general acute care hospital (GACH). During a review of Resident 21's Transfer Form dated 6/29/2024, it indicated Resident 21 was transferred to the GACH for abdominal pain. During a concurrent interview and record review on 2/2/2025 at 10:06 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 21's medical records were reviewed. LVN 2 stated Resident 21 was transferred out to the GACH on 6/29/2024 but there was no documentation in the progress notes to indicate what happened to the resident that they needed to be transferred out. LVN 2 also stated there was no Change of Condition (COC) form to indicate what change Resident 21 experienced. LVN 2 stated it was important to fill out the COC when there is a change in baseline so that nurses can monitor the resident appropriately and report to the physician after the change was identified. During a review of the facility's policy and procedure titled, Change of Condition Notification, dated, 10/1/2023, it indicated the licensed nurse will assess the resident's change of condition and document the observations and symptoms.		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to: 1. Transmit the Minimum Data Set ([MDS] - a resident assessment tool) within 14 days after completion to Center of Medicare and Medicaid Services (CMS) for two of 12 sampled residents (Resident 29 and 34). This deficient practice had the potential to result in billing error and inaccurate data on resident care needs. Findings: a. During a review of Resident 29's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated, Resident 29 was initially admitted to the facility on [DATE]and readmitted on [DATE]. The Admission Record indicated Resident 29's diagnoses included hypertension ([HTN] high blood pressure) and congestive heart failure ([CHF] - a heart disorder which causes the heart not to pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 29's MDS assessment, dated 12/20/2024, the MDS indicated, Resident 29's cognitive (ability to think and reason) skills for daily decision making was intact. The MDS indicated, Resident 29 required set-up assistance (helper sets up, resident completes activity) from staff with oral hygiene, toileting hygiene, and upper body dressing. b. During a review of Resident 34's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated, Resident 34 was admitted to the facility on [DATE]. The Admission Record indicated Resident 34's diagnoses included anemia (a condition where the body does not have enough healthy red blood cells) and failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 34's MDS assessment, dated 12/22/2024, the MDS indicated, Resident 34's cognitive (ability to think and reason) skills for daily decision making was intact. The MDS indicated, Resident 34 was totally dependent (helper does all of the effort) from staff with eating, oral hygiene, and toileting hygiene. (continued on next page)		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent phone interview and record review on 2/1/2025 at 3:58 p.m., with the Minimum Data Set Nurse (MDSN), Resident 29's MDS annual assessment, dated 12/20/2024 and Resident 34's MDS quarterly assessment, dated 12/22/2024, were reviewed. The MDSN stated Resident 29's MDS Assessment Reference Date ([ARD] - the specific date used as the end point of the observation period when assessing a resident's condition) was 12/20/2024 and had not been transmitted to the CMS. The MDSN stated Resident 34's MDS ARD was 12/22/2024 and had not been submitted to the CMS. The MDSN stated Resident 29 and 34 MDS assessment should had been transmitted to the CMS within 14 days of the ARD. The MDSN stated there was a delay of informing the CMS about the care provided to Resident 29 and 34 for not transmitting the MDS assessment in a timely manner. During an interview on 2/1/2025 at 4:14 p.m. with the DON, the DON stated by not transmitting the MDS assessment in a timely manner, resident care and facility reimbursement would be affected. During a review of the facility's policy and procedure (P&P) titled, Minimum Data Set, dated dated [DATE], the P&P indicated, Within seven days after the completion of a resident assessment, the MDS coordinator will encode the assessment date, annual assessment updates, significant change in status, admission assessment, quarterly review assessment, subset of items upon a residents transfer, reentry, discharge and death edit according to HCFA specification and lock the record, and the record is ready for transmission.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48712 Based on interview and record review, the facility failed to: 1. Ensure one out of four sampled residents (Resident 40) received a Pre-Admission Screening and Resident Review ([PASRR] - a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) level II assessment. This deficient practice had the potential to result in Resident 40 not receiving the required services for her mental health condition. 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 including hypertension (HTN-high blood pressure), schizophrenia (a mental illness that is characterized by disturbances in thought), and diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing) During a review of Resident 40's History and Physical (H&P), dated 12/21/2024, the H&P indicated Resident 40 has the capacity to understand and make decisions. During a review of Resident 40's Minimum Data Set ([MDS] a resident assessment tool) dated 12/10/2024, the MDS indicated Resident 40's had severe cognitive (process of thinking and reasoning) impairment. Resident 40 needed maximal assistance toileting and lower body dressing. Resident 40 was dependent on staff for bathing. During a concurrent interview and record review on 2/2/2025 at 9:57 a.m. with the Medical Records Director (MRD), Resident 40's PASRR level I was reviewed. The PASRR level I, dated 12/23/2024 was positive. The PASRR indicated a level II evaluation was required. A review of the Department of Health Care Services letter, dated 12/23/2024, indicated the level II evaluation was not completed because Resident 40 has a duplicate PASRR on file. The MRD stated she was supposed to go back into the system to follow up on the PASRR but she did not. The MRD stated a PASRR is needed to ensure proper placement of residents. A Level II PASRR is needed because they provide recommendations that are helpful in formulating a care plan. The MRD stated since the level II evaluation was not completed, the resident may not be receiving the needed services. During a review of the facility's policy and procedure (P&P) titled, Preadmission Screening, dated August 2014, the P&P indicated if a resident is identified during the Level I screening as having a possible mental illness, the recipient must be referred to a Level II.		

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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** 49131 Based on interview, and record review, the facility failed to: 1. Develop a care plan for a peripherally inserted central catheter (PICC- a thin, soft tube that is placed into a vein, usually in the upper arm to deliver fluids or medication) line for one of three sampled residents (Resident 18). This deficient practice had the potential to result in a lack of meeting necessary care goals. Findings: During a review of Resident 18's Face Sheet, it indicated Resident 18 was admitted on [DATE] with diagnoses that included unspecified respiratory disorder, and other disorders of the kidney and ureter (the tube that carries urine from the kidney to the bladder). During a review of Resident 18's (MDS - a resident assessment tool) dated 1/23/2025, it indicated Resident 18 was unable to complete a brief interview for mental status. During a review of Resident 18's Progress Note dated 1/2/2025 to 1/10/2025, it indicated Resident 18 had a PICC line to the right upper arm and no swelling or redness was noted. During a concurrent observation and interview on 2/1/2025 at 6:21 p.m. with the Director of Nursing (DON), Resident 18's right upper arm was assessed. The DON lifted Resident 18's right arm and stated Resident 18 had a PICC line. During a concurrent interview and record review on 2/2/2025 at 11:23 a.m., with the DON, Resident 18's medical records were reviewed. The DON stated registered nurses (RN) are responsible for PICC lines. The RNs monitor the PICC line which included changing the dressing every 7 days or when it is soiled or lifting, flushing the line to ensure it is patent (free from obstruction), measuring the arm circumference, making sure there is no swelling or redness at the site. The DON stated none of these tasks were done after reviewing Resident 18's medical records. The DON also stated there was no care plan that specifically addressed Resident 18's PICC line goals and interventions. The DON stated the care plan for PICC line was important because it would identify areas that needed monitoring concerning the PICC line and if interventions are necessary.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49131 Based on interview, and record review, the facility failed to: 1. Ensure one out of three sample residents (Resident 21), had vital signs taken every shift as ordered by the physician. This deficient practice had the potential for Resident 21 to experience a delay in interventions if there were any significant changes in their vital signs. Findings: During a review of Resident 21's Face Sheet, it indicated Resident 21 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included seizures, and shortness of breath. During a review of Resident 21's Order Summary Report, an order was placed on 5/8/2024 to monitor vital signs every shift. During a review of Resident 21's Minimum Data Set (MDS - a resident assessment tool) dated 10/1/2024, it indicated Resident 21 was cognitively intact (ability to reason, understand, remember, judge, and learn). During a review of Resident 21's Vitals Summary, dated 01/2025, a sample of Resident 21's vital signs is recorded as follows: Blood Pressure: 1/21/2025 10:22 a.m. 123/69 1/23/2025 6:24 a.m. 126/71 1/23/2025 9:29 a.m. 126/75 1/24/2025 5:59 a.m. 126/64 1/24/2025 10:48 p.m. 126/67 Temperature: 1/21/2025 1:18 p.m. 98.2 Fahrenheit (F) 1/24/2025 10:48 p.m. 97.5 F 1/25/2025 3:50 a.m. 97.2 F 1/25/2025 1:46 p.m. 97.5 F (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/26/2025 9:33 p.m. 97.8 F 1/27/2025 5:27 a.m. 98 F Pulse: 1/21/2025 1:18 p.m. 78 beats per minute (bpm) 1/23/2025 6:24 a.m. 67 bpm 1/23/2025 9:29 a.m. 69 bpm 1/24/2025 5:59 a.m. 80bpm 1/24/2025 10:48 p.m. 78 bpm 1/25/2025 3:50 a.m. 80 bpm 1/25/2025 8:41 a.m. 74 bpm 1/25/2025 1:46 p.m. 74 bpm Respirations: 1/21/2025 1:18 p.m. 17 breaths per minute 1/23/2025 9:31 a.m. 17 breaths per minute 1/23/2025 4:59 p.m. 18 breaths per minute 1/24/2025 7:12 p.m. 17 breaths per minute 1/25/2025 3:50 a.m. 87 breaths per minute 1/25/2025 1:43 p.m. 18 breaths per minute 1/25/2025 1:46 p.m. 18 breaths per minute During a concurrent interview, and record review on 2/2/2025 at 2:25 p.m. with Licensed Vocational Nurse (LVN) 2, Resident 21's Order Summary Report and Vitals Summary was reviewed. LVN 2 reviewed Resident 21's Order Summary Report and stated Resident 21 had an order to check their vital signs every shift, and stated all residents should have their vital signs checked every shift regardless of if they had an order or not. LVN 2 reviewed Resident 21's Vitals Summary and stated there are a lot of missing entries amongst the days, and stated there are some days where the vital signs was taken just once or twice a day where the staff should have checked it at least three times per day. Resident 21 stated it is important to check the vital signs as ordered because if there are any significant changes in the vital signs, the nurse would have to notify the doctor regarding the change and fill out a change of condition form. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P), dated 2/6/2003, the P&P indicated to ensure optimum assessment and monitoring of resident's change of condition by monitoring vital signs and to document the vital signs on the vital signs flow sheet in the residents medical record. Vitals signs include temperature, pulse, respirations, and blood pressure.		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to: 1. Ensure a vision care service was provided for one of one sampled resident (Resident 15). This deficient practice had the potential to result in Resident 15's worsening of eye vision that would negatively affect his quality of life. Findings: During a review of Resident 15's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated, Resident 15 was initially to the facility on [DATE] and readmitted on [DATE]. The Admission Record indicated, Resident 15's diagnoses included optic atrophy (a condition that occurs when the optic nerve fibers are damaged , causing vision loss), macular degeneration (an eye disease that can blur your central vision), and hypertension ([HTN] - high blood pressure. During a review of Resident 15's History and Physical (H&P), dated 8/12/2024, the H&P indicated, Resident 15 had the capacity to understand and make decisions. During a review of Resident 15's Minimum Data Set ([MDS] - a resident assessment tool) assessment, dated 1/3/2025, the MDS indicated, Resident 15's cognitive (ability to think and reason) skills for daily decision making was intact. The MDS indicated, Resident 15 was totally dependent (helper does all of the effort) from staff with toileting hygiene, upper body dressing, and personal hygiene. The MDS indicated, Resident 15 had corrective lenses and severely impaired vision. During a review of Resident 15's Care Plan, titled Impaired Visual Function, dated 10/17/2024, the Care Plan goal indicated Resident 15 would not have a decline in visual function through the next review date. The care plan interventions included to arrange consultation with eye care practitioner as required and ensure appropriate visual aids are available. During an interview on 2/1/2025 at 8:57 a.m., with Resident 15 in his room, Resident 15 stated he needed a new prescription eyeglasses so he could clearly see. Resident 15 stated he had been telling facility staff that he need to see an eye doctor to check his vision. Resident 15 stated his vision was blurry and could only see shadow. During a concurrent interview and record review on 2/1/2025 at 3:36 p.m., with the Social Service Designee (SSD), Resident 15's clinical records were reviewed. The DSD stated there was documentation indicating Resident 15 was referred to the optometrist (the profession of examining the eyesight and prescribing corrective lenses to improve vision and of diagnosing and sometimes treating diseases of the eye) to check his vision. The DSD stated it was her responsibility to refer Resident 15 to the optometrist. The DSD stated the risk of not referring Resident 15's to the optometrist could result in worsening of his vision that would lead to depression and would affect his functioning due to lack of independence. (continued on next page)		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/2/2025 at 10:02 a.m., with the Director of Nursing (DON), the DON stated progressive vision loss would cause permanent blindness and would affect Resident 15's self-esteem (how we value and perceive ourselves). During a review of the facility's policy and procedure (P&P), titled Referrals to Outside Services, dated 10/1/2023, the P&P indicated, the Director of Social Services is responsible for locating agencies and programs that meet the needs of the residents. During a review of the facility's P&P, titled Resident Rights - Quality of Life, dated 10/1/2023, the P&P indicated, Facility staff provides care and services that ensure the resident's abilities in activities of daily living do not diminish while in the care of the facility. The P&P indicated each resident shall be care for in a manner that promotes and enhances the quality of life.		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on observation, interview, and record review, the facility failed to: 1. Ensure resident with long thick elongated (nail plate grows longer than the nail bed) toenails received podiatry (profession dealing with the specialized care of the feet) care services for one of one sampled resident (Resident 24). This deficient practice had the potential to result in foot discomfort, infection, and decline in physical mobility for Resident 24. Findings: During a review of Resident 24's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated, Resident 24 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The Admission Record indicated, Resident 24's diagnoses included cellulitis (a skin infection that causes swelling and redness), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 24's MDS assessment, dated 11/9/2024, the MDS indicated, Resident 24's cognitive (ability to think and reason) skills for daily decision making was intact. The MDS indicated, Resident 24 required moderate assistance (helper does less than half the effort) from staff with oral hygiene, upper body dressing, and personal hygiene. During a concurrent observation and interview on 2/1/2025 at 8:46 a.m., with Resident 24 in his room, Resident 24 had a long thick elongated toenails on both feet. Resident 24 stated he had been telling the facility staff about his long toenails and requested to see a podiatrist, but nothing had been done. Resident 24 stated his long toenails prevented him from wearing a socks because it causes discomfort and irritation. During a concurrent observation and interview on 2/1/2025 at 3:278 p.m., at Resident 24's room, with Social Service Designee (SSD), the SSD stated Resident 24 had a long thick toenails that needs to be trimmed by the podiatrist. The SSD stated the previous SSD did not refer Resident 24 to the podiatrist. The SSD stated the last visit by the podiatrist to the facility was 10/29/2024. The SSD stated podiatry care was one of the services offered by the facility to all residents. The SSD stated Resident 24 would be embarrassed if other residents would see his long thick toenails and his quality of life would be affected. The SSD stated she will refer Resident 24 to the podiatrist immediately because of the risk of foot pain and infection. During a review of the facility's policy and procedure (P&P) titled, Foot Care, dated 2/25/2008, the P&P indicated, To provide hygienic care of the feet, to prevent skin breakdown or infections and to promote comfort. (continued on next page)		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P, titled Referrals to Outside Services, dated 10/1/2023, the P&P indicated, the Director of Social Services is responsible for locating agencies and programs that meet the needs of the residents.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49131 Based on observation, interview, and record review, the facility failed to: 1. Ensure one out of one resident (Resident 18) had their peripherally inserted central catheter (PICC- a thin, soft tube that is placed into a vein, usually in the upper arm to deliver fluids or medication) line monitored and the dressing changed as indicated. This deficient practice had the potential for staff to miss any complications associated with a PICC line and for Resident 18 to experience a delay in interventions. Findings: During a review of Resident 18's Progress Note dated 1/2/2025, it indicated Resident 18 would be returning from the hospital with a PICC line for antibiotics. During a review of Resident 18's Face Sheet, it indicated Resident 18 was admitted on [DATE] with diagnoses that included unspecified respiratory disorder, and other disorders of the kidney and ureter (the tube that carries urine from the kidney to the bladder). During a review of Resident 18's (MDS - a resident assessment tool) dated 1/23/2025, it indicated Resident 18 was unable to complete a brief interview for mental status. During a review of Resident 18's Progress Note dated 1/2/2025 to 1/10/2025, it indicated Resident 18 had a PICC line to the right upper arm and no swelling or redness was noted. During a concurrent observation and interview on 2/1/2025 at 6:21 p.m. with the Director of Nursing (DON), Resident 18's right upper arm was assessed. The DON lifted Resident 18's right arm and stated Resident 18 had a PICC line and the dressing is soiled and should have been changed. The DON stated she was unaware Resident 18 had a PICC line and was unaware of when the last time the PICC line dressing was changed or documented on but will address the issue immediately. During a concurrent interview and record review on 2/2/2025 at 11:23 a.m., with the DON, Resident 18's medical records were reviewed. The DON stated registered nurses (RN) are responsible for PICC lines. The RNs monitor the PICC line which included changing the dressing every 7 days or when it is soiled or lifting, flushing the line to ensure it is patent (free from obstruction), measuring the arm circumference, making sure there is no swelling or redness at the site. The DON stated none of these tasks were done after reviewing Resident 18's medical records. The DON stated these tasks and monitoring for the PICC line are important and are done to ensure there are no complications such as infection or infiltration (when fluid leaks out into the tissues under the skin where the tube has been put into the vein).		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49131 Based on observation, and interview, the facility failed to: 1. Ensure one of one sampled residents (Resident 195), had a dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) emergency kit at the bedside. This deficient practice had the potential for Resident 195 to experienced delayed interventions due to bleeding of the dialysis site. Findings: During an interview on 2/1/2025 at 9:17 a.m. with Resident 195, Resident 195 stated he receives dialysis every Tuesday, Thursday, and Saturday. During an observation on 2/2/2025 at 1:56 p.m. at Resident 195's room, no dialysis emergency kit was seen on his nightstand or by his bedside. During a review of Resident 195's Face Sheet, it indicated Resident 195 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease, acute kidney failure, and is dependent on dialysis. During a review of Resident 195's (MDS - a resident assessment tool), dated 1/28/2025, it indicated Resident 195 moderately impaired cognition (ability to reason, understand, remember, judge, and learn). During a review of Resident 195's Order Summary Report, it indicated Resident 195 received dialysis every Tuesday, Thursday, and Saturday at 1:15 p.m. During an observation on 2/1/2025 at 4:41 p.m. with Licensed Vocational Nurse (LVN) 4 in Resident 195's room, Resident 195's room was searched for a dialysis emergency kit. LVN 4 looked into Resident 195's closet, nightstand and surrounding area in the room and no dialysis emergency kit was found. During an interview on 2/1/2025 at 4:53 p.m. with LVN 4, LVN 4 stated the dialysis emergency kit should be at the bedside for all residents who are on dialysis. LVN 4 stated the dialysis emergency kit contains gauze, tape, and a tourniquet and the resident's should have one readily at the bedside in case the resident experiences bleeding at the site and the nurse		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 48712 Based on interview and record review, the facility failed to: 1. Ensure four out of five sampled employees had a completed orientation skills check list upon hire. This deficient practice had the potential to result in residents receiving substandard quality of care because staff had not been deemed competent through a skills assessment. Findings: During a concurrent interview and record review on 2/1/2025 at 4:15 p.m. with the Director of Staff Development (DSD), the employee files of three Certified Nursing Assistants (CNA) and one Licensed Vocational Nurse (LVN) was reviewed. The DSD stated everyone needs to have a skills check list to ensure they know what they are doing. The DSD stated the skills checklist should be completed upon hire and every year. The check list gives a summary of what you need to do and that you have been trained. The DSD stated whomever trains the employee needs to sign the form to accept responsibility for providing the training. If the form is not signed, it wasn't done. The DSD stated if you don't have a completed skills checklist they don't know you are competent. Not being competent could result in poor quality of care to the resident. Employee file review: 1. CNA 1 was hired on 1/22/2024. CNA 1's orientation skills checklist, dated 1/22/2024, was not signed by a trainer. CNA 1 did not have an annual skills checklist completed for January 2025. 2. CNA 2 was hired on 7/1/2024. CNA 2's orientation skills check list was not dated. The checklist did not contain a signature for CNA 2 or a trainer. 3. CNA 3 was hired on 11/14/2024. CNA 3's orientation skills checklist dated 11/14/2024, did not contain a signature of a trainer. 4. LVN 1 was hired on 8/29/2024. LVN 1's employee file did not contain an orientation skills checklist.		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 48712 Based on observation, interview, and record review, the facility failed to: 1. Ensure the Nursing Hours Per Patient Day (NHPPD)- a measure of the average number of hours of nursing care provided to each patient in a hospital or nursing facility) information was posted in an area that was easily viewable by residents/the public. This deficient practice had the potential to result in residents/the public not being aware if the facility had enough staff to provide safe/quality care. Findings: During a concurrent observation and interview on 2/1/2025 at 7:45 a.m. with Licensed Vocational Nurse (LVN) 5 at the nurse's station, it was observed there was no NHPPD information posted. LVN 5 stated the NHPPD information is supposed to be posted on the bulletin board. LVN 5 stated NHPPD has to be in a place that is visible to everyone so they know what the census is and if there is enough staff. LVN 5 stated the facility has to meet staffing requirements to meet the needs of the residents. During an interview on 2/1/2025 at 2:15 p.m. with the Director of Staff Development (DSD), the DSD stated the NHPPD gives the ratio of nurses to residents. The DSD stated there should be a new posting everyday in a place that can be easily seen by the public. The numbers let others know the facility has enough staff to provide quality care. During a review of the facility's policy and procedure (P&P) titled, Nursing Department - Staffing, Scheduling & Postings, dated January 2024, the P&P indicated nurse staffing data must be posted in a prominent place readily accessible to residents and visitors.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on observation, interview, and record review, the facility failed to: 1. Ensure a Narcotic Count Record (a log signed by licensed nurses during shift change endorsing over responsibility for the controlled substances in the cart) was completed accurately. This deficient practice increased the risk of loss or diversion of controlled medication. 2. Ensure Resident 96's medications of Zinc Sulfate (vitamin mineral supplement used to treat or prevent low levels of zinc) and Olopatadine HCL Ophthalmic solution (an eye drops used to treat itching of the eye) are available in the medication cart. This deficient practice had the potential to result in harm to Resident 96 by not administering medication and following physician orders to meet resident individual medication needs. Findings: 1. During a concurrent interview and record review on 2/1/2025 at 1:57 p.m., with Licensed Vocational Nurse 2 (LVN 2), medication cart 1 Narcotic Count Record was reviewed. LVN 2 stated there was at least one missing initials of licensed nurses on shift change on 1/2/2025, 1/5/2025, 1/12/2025, 1/13/2025, 1/14/2025, 1/15/2025, 1/18/2025, 1/19/2025, 1/21/2025, 1/22/2025, 1/23/2025, 1/26/2025, 1/27/2025, 1/28/2025, 1/30/2025, and 1/31/2025. LVN 2 stated incoming and outgoing licensed nurses should sign consistently on the Narcotic Count Record. LVN 2 stated if there were missing initials of licensed nurses on the Narcotic Count Record there would be no validation that Narcotic Count was done by the incoming and outgoing licensed nurses and there was a risk for theft of the narcotic medications. During an interview on 2/1/2025 at 2:17 p.m., with the Director of Nursing (DON), the DON stated there was a risk for drug diversion if the Narcotic Count Record was not completed accurately. During a review of the facility's policy and procedure (P&P) titled, Controlled Drugs, dated 1/1/2014, the P&P indicated, Controlled scheduled drugs shall be reconciled at least every shift by counting the drugs and verifying the count with the number recorded on the Controlled Drug Record for each drug. The count will be conducted by the licensed nurse assigned to medication administration going off duty and the licensed nurse coming on duty assigned to medication administration. 2. During a review of Resident 96's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated, Resident 96 was admitted to the facility on [DATE]. The Admission Record indicated, Resident 96's diagnoses included pneumonia, hypertension ([HTN] - high blood pressure), and muscle weakness. During a review of Resident 96's History and Physical (H&P), dated 2/2/2025, the H&P indicated, Resident 96 did not have the capacity to understand and make decisions. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 96's MDS assessment, dated 1/28/2025, the MDS indicated, Resident 96's cognitive (ability to think and reason) skills for daily decision making was severely impaired. During a review of Resident 96's Order Summary Report (a document containing active orders), dated 1/24/2025, indicated Resident 96's physician prescribed Zinc Sulfate 220 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) once a day for supplement and Olopatadine HCL Ophthalmic solution to apply one drop in both eyes two times a day for eye itching. During a concurrent medication pass observation and interview on 2/2/2025 at 8:59 a.m., with Licensed Vocational Nurse 3 (LVN 3), LVN 3 observed not giving the Zinc Sulfate and Olopatadine HCL Ophthalmic solution eye drops to Resident 96. LVN 3 stated she did not have the stock medications of Zinc Sulfate and Olopatadine HCL Ophthalmic solution eye drops and that was the reason why she failed to administer the medication to the resident. LVN 3 stated each medications has its own indication for the resident and should be given as prescribed by the physician. LVN 3 stated all medications should be available and accessible at all times. LVN 3 stated she will order the medications immediately to the pharmacy. During a review of the facility's P&P titled, Medication and Treatment Administration, dated 1/5/2017, the P&P indicated, Medications and treatments will be administered as prescribed in accordance with good nursing principles and practices. The P&P indicated doses shall be administered within two hours of prescribed time unless otherwise indicated by the prescriber.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 47923 Based on interview and record review, the facility failed to: 1. Ensure four out of eight sampled residents (Residents 4, 5, 10, and 24) had a Medication Regimen Review ([MRR]- a review of medications to identify problems/errors) completed monthly by the pharmacist. This deficient practice put Residents 4, 5, 10, and 24 at risk of having a drug interaction or being overmedicated. Findings: a. During a review of Resident 4's Admission Record, the Admission Record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including hypertension (HTN-high blood pressure), diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), and dementia (a progressive state of decline in mental abilities). During a review of Resident 4's History and Physical (H&P), dated 8/22/2023, the H&P indicated Resident 4 does not have capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set ([MDS] a resident assessment tool) dated 2/7/2025, the MDS indicated Resident 4 had severe cognitive (ability to think and reason) impairment. Resident 4 was dependent on staff for toileting, bathing, and dressing the lower body. During a concurrent interview and record review on 2/01/2025 at 5:14 p.m. with the Director of Nursing, we attempted to review the MRR's for October 2024 to December 2024. There is no evidence the pharmacist completed an MRR October 2024 to December 2024 for Resident 4. The DON stated an MRR is needed to check if there are any drug interactions. The review allows the pharmacist to make recommendations. If the review is not completed there may be drug interactions or the resident may be overmedicated. The DON stated if the MRR is not completed the resident may have a negative outcome. b. During a review of Resident 5's Admission Record, the Admission Record indicated Resident 5 was admitted to the facility on [DATE] with diagnoses including hypertension (HTN-high blood pressure), diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), and congestive heart failure ([CHF]- a heart disorder which causes the heart to not pump the blood efficiently). During a review of Resident 5's History and Physical (H&P), dated 11/22/2024, the H&P indicated Resident 5 had fluctuating capacity to understand and make decisions. During a review of Resident 5's Minimum Data Set ([MDS] a resident assessment tool) dated 11/24/2024, the MDS indicated Resident 5 had moderate cognitive (ability to think and reason) impairment. Resident 5 was dependent on staff for toileting, bathing, and dressing the lower body. (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on 2/01/2025 at 5:14 p.m. with the Director of Nursing, we attempted to review the MRR's for October 2024 to December 2024. There is no evidence the pharmacist completed an MRR October 2024 to December 2024 for Resident 5. The DON stated an MRR is needed to check if there are any drug interactions. The review allows the pharmacist to make recommendations. If the review is not completed there may be drug interactions or the resident may be overmedicated. The DON stated if the MRR is not completed the resident may have a negative outcome. c. During a review of Resident 10's Admission Record, the Admission Record indicated Resident 10 was admitted to the facility on [DATE] with diagnoses including dysphagia (difficulty swallowing), diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), and intellectual disabilities. During a review of Resident 10's History and Physical (H&P), dated 12/18/2024, the H&P indicated Resident 10 has capacity to understand and make decisions. During a review of Resident 10's Minimum Data Set ([MDS] a resident assessment tool) dated 12/4/2024, the MDS indicated Resident 10's cognition (ability to think and reason) was intact. Resident 10 required supervision with eating, toileting, and upper body dressing. Resident 10 needed moderate assistance bathing and dressing the lower body. During a concurrent interview and record review on 2/01/2025 at 5:14 p.m. with the Director of Nursing, we attempted to review the MRR's for October 2024 to December 2024. There is no evidence the pharmacist completed an MRR October 2024 to December 2024 for Resident 10. The DON stated an MRR is needed to check if there are any drug interactions. The review allows the pharmacist to make recommendations. If the review is not completed there may be drug interactions or the resident may be overmedicated. The DON stated if the MRR is not completed the resident may have a negative outcome. 48712 d. During a review of Resident 24's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated 24 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The Admission Record indicated, Resident 24's diagnoses included cellulitis (a skin infection that causes swelling and redness), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 24's MDS assessment, dated 11/9/2024, the MDS indicated, Resident 24's cognitive (ability to think and reason) skills for daily decision making was intact. The MDS indicated, Resident 24 required moderate assistance (helper does less than half the effort) from staff with oral hygiene, upper body dressing, and personal hygiene. During a concurrent interview and record review on 2/2/2025 at 11:01 a.m., with the Director of Nursing (DON), Medication Regimen Review Report from 12/1/2024 through 2/1/2025 was reviewed. The DON stated Resident 24's drug regimen was not reviewed by the pharmacy consultant from 12/1/2024 through 2/1/2025. The DON stated all residents drug regimen should be reviewed once a month by the pharmacy consultant in order to ensure residents not receiving inappropriate medications.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on observation, interview, and record review, the facility failed to: 1. Ensure it was free of a medication error rate of five percent (5%) or greater, as evidenced by the identification of two out of 26 medication opportunities (observations during medication administration) for error, to yield a cumulative error rate of 7.69% for one of four sampled residents (Resident 96) observed during the medication administration facility task by failing to: 2. Administer Resident 96's Zinc Sulfate (vitamin mineral supplement used to treat or prevent low levels of zinc) and Olopatadine HCL Ophthalmic solution (an eye drops used to treat itching of the eye) as prescribed by the physician. This deficient practice had the potential to result in harm to Resident 96 by not administering medication and following physician orders to meet resident individual medication needs. Findings: During a review of Resident 96's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated, Resident 96 was admitted to the facility on [DATE]. The Admission Record indicated, Resident 96's diagnoses included pneumonia, hypertension ([HTN] - high blood pressure), and muscle weakness. During a review of Resident 96's History and Physical (H&P), dated 2/2/2025, the H&P indicated, Resident 96 did not have the capacity to understand and make decisions. During a review of Resident 96's MDS assessment, dated 1/28/2025, the MDS indicated, Resident 96's cognitive (ability to think and reason) skills for daily decision making was severely impaired. During a review of Resident 96's Order Summary Report (a document containing active orders), dated 1/24/2025, indicated Resident 96's physician prescribed Zinc Sulfate 220 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) once a day for supplement and Olopatadine HCL Ophthalmic solution to apply one drop in both eyes two times a day for eye itching. During a concurrent medication pass observation and interview on 2/2/2025 at 8:59 a.m., with Licensed Vocational Nurse 3 (LVN 3), LVN 3 observed not giving the Zinc Sulfate and Olopatadine HCL Ophthalmic solution eye drops to Resident 96. LVN 3 stated she did not have the stock medications of Zinc Sulfate and Olopatadine HCL Ophthalmic solution eye drops and that was the reason why she failed to administer the medication to the resident. LVN 3 stated each medications has its own indication for the resident and should be given as prescribed by the physician. LVN 3 stated she omitted two medications and that was considered as medication error. LVN 3 stated she will order the medications immediately to the pharmacy. (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Medication and Treatment Administration, dated 1/5/2017, the P&P indicated, Medications and treatments will be administered as prescribed in accordance with good nursing principles and practices. The P&P indicated doses shall be administered within two hours of prescribed time unless otherwise indicated by the prescriber.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on observation, interview, and record review, the facility failed to: 1. Ensure routine room temperature monitoring and documentation were in place to ensure medications were within the temperature ranges as specified by the drug manufacturers, in one of one medication storage room. 2. Label with an opened date one vial (a small container, usually made of glass or plastic used to store liquids) of Aplisol (a medication that is used as a diagnostic tool to help identify tuberculosis infections in individuals who are at a higher risk of developing the active disease) solution found at medication storage refrigerator. 3. Label with an opened date one vial of lorazepam (a medication indicated for treatment of anxiety) for Resident 9 found at medication storage refrigerator. 4. Label with an opened date one vial of Admelog (type of insulin medication) insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) for Resident 4 found at medication cart 1. 5. Label with an opened date one vial of Admelog insulin for Resident 11 found at medication cart 1. These deficient practices had the potential for harm to residents due to potential loss of strength of the medicine. Findings 1. During a concurrent observation and interview on [DATE] at 1:24 p.m., with Licensed Vocational Nurse 1 (LVN 1), of the medication room storage, LVN 1 stated there was no room temperature monitoring log. LVN 1 stated it was very important to monitor and document the temperature of the medication room storage because it could affect the stability of the medication that would decrease the effectiveness of the medication. 2. During a concurrent observation and interview on [DATE] at 1:28 p.m., with LVN 1, of the medication room storage, found one vial of Aplisol solution with no label with an opened date. LVN 1 stated it was unknown when the Aplisol solution was opened since it was not labeled. LVN 1 stated the Aplisol solution is good only for 30 days once it was opened. LVN 1 stated she will dispose the one vial of Aplisol solution immediately because it was not safe to administer to resident and could cause drug adverse reaction (unwanted, uncomfortable, or dangerous effects that drugs may have). (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 9's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated, Resident 9 was admitted to the facility on [DATE]. The Admission Record indicated Resident 9's diagnoses included anxiety disorder (a mental health condition that involves excessive and persistent feelings of fear and worry) and congestive heart failure ([CHF] - a heart disorder which causes the heart not to pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 9's MDS assessment, dated [DATE], the MDS indicated, Resident 9's cognitive (ability to think and reason) skills for daily decision making was severely impaired. The MDS indicated, Resident 9 was totally dependent (helper does all of the effort) from staff with eating, oral hygiene, and lower body dressing. During a review of Resident 9's Order Summary Report (a document containing active orders), dated [DATE], indicated Resident 9's physician prescribed lorazepam 2 milligrams ([mg] - metric unit of measurement , used for medication dosage and/or amount) per millimeter ([ml]- unit of measurement) to give 0.25 ml every 3 hours as needed for anxiety disorder. 4. During a review of Resident 4's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated, Resident 4 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The Admission Record indicated Resident 4's diagnoses included Diabetes Mellitus ([DM] - a disorder characterized by difficulty in blood sugar control and poor wound healing) and dementia (a progressive state of decline in mental abilities). During a review of Resident 4's MDS assessment, dated [DATE], the MDS indicated, Resident 4's cognitive (ability to think and reason) skills for daily decision making was severely impaired. The MDS indicated, Resident 4 was totally dependent (helper does all of the effort) from staff with oral hygiene, toileting hygiene, and lower body dressing. During a review of Resident 4's Order Summary Report (a document containing active orders), dated [DATE], indicated Resident 4's physician prescribed insulin Admelog to inject subcutaneously ([SQ] - beneath or under the layer of the skin) there times a day before meals at 6:30 a.m., 11:30 a.m., 4:30 p.m., and at bedtime per sliding scale (increasing administration of the pre-meal insulin dose based on the blood sugar level before the meal): if blood sugar ,d+[DATE] = 0, ,d+[DATE] = 2 units, ,d+[DATE] = 4 units, , d+[DATE] = 6 units, ,d+[DATE] = 8 units, ,d+[DATE] = 10 units, and to call md if blood sugar less than 40 or above 400. 5. During a review of Resident 11's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated, Resident 11 was admitted to the facility on [DATE]. The Admission Record indicated Resident 11's diagnoses included Diabetes Mellitus ([DM] - a disorder characterized by difficulty in blood sugar control and poor wound healing) and anemia (a condition where the body dos not have enough healthy red blood cells). During a review of Resident 11's MDS assessment, dated [DATE], the MDS indicated, Resident 11's cognitive (ability to think and reason) skills for daily decision making was moderately impaired. The MDS indicated, Resident 11 required supervision (helper provides verbal cues) from staff with toileting hygiene, upper body dressing, and personal hygiene. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 11's Order Summary Report (a document containing active orders), dated [DATE], indicated Resident 4's physician prescribed insulin Admelog to inject subcutaneously ([SQ] - beneath or under the layer of the skin) three times a day before meals at 6:30 a.m., 11:30 a.m., 4:30 p.m., and at bedtime per sliding scale (increasing administration of the pre-meal insulin dose based on the blood sugar level before the meal): if blood sugar ,d+[DATE] = 0, ,d+[DATE] = 2 units, ,d+[DATE] = 4 units, ,d+[DATE] = 6 units, ,d+[DATE] = 8 units, ,d+[DATE] = 10 units, and to call md if blood sugar less than 40 or above 400. During a concurrent observation and interview on [DATE] at 1:44 p.m., of medication cart one with Licensed Vocational Nurse 2 (LVN 2), found one opened Admelog insulin with no label with an opened date for Resident 4 and one opened Admelog insulin with no label with an opened date for Resident 11. LVN 2 stated Resident 4 and 11's Admelog insulin was unknown it was opened since it was not labeled at an open date. LVN 2 stated Admelog insulin is good only for 28 days per manufacture guidelines. LVN 2 stated it was important to label the insulin with an opened date to know the validity and when to discard the medication. LVN 2 stated giving expired insulin would be ineffective in treating Resident 4 and 11's blood sugar. During a review of the facility's policy and procedure (P&P) titled, Labeling and Storage of Drugs, dated [DATE], the P&P indicated, All drugs shall be labeled in compliance with state and federal law. The P&P indicated opened multidose injectables will be dated, initialed, and stored according to the manufactures directions.		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48712 Based on interview and record review, the facility failed to: 1. Ensure one of four sampled residents (Resident 5) had a Complete Blood Count ([CBC] a blood test that measures the number and type of cells in your blood), and Comprehensive Metabolic Panel ([CMP] a blood test that measures 14 substances in your blood to provide an overall picture of your body's chemical balance) completed monthly per physician's order. This deficient practice resulted in a lack of required monitoring of Resident 5's health status. Findings: During a review of Resident 5's Admission Record, the Admission Record indicated Resident 5 was admitted to the facility on [DATE] with diagnoses including hypertension (HTN-high blood pressure), diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), and congestive heart failure ([CHF]- a heart disorder which causes the heart to not pump the blood efficiently). During a review of Resident 5's History and Physical (H&P), dated 11/22/2024, the H&P indicated Resident 5 had fluctuating capacity to understand and make decisions. During a review of Resident 5's Minimum Data Set ([MDS] a resident assessment tool) dated 11/24/2024, the MDS indicated Resident 5 had moderate cognitive (ability to think and reason) impairment. Resident 5 was dependent on staff for toileting, bathing, and dressing the lower body. During a review of Resident 5's care plan, dated 12/7/2021, the care plan indicated Resident 5 was on diuretic (medication that helps remove excess fluid from the body) therapy and at risk for dehydration. The care plan indicated as an intervention, the facility would complete lab tests as ordered and report the sodium and potassium (two tests included in a CMP) to the physician. During a review of Resident 5's care plan, dated 8/11/2024, the care plan indicated Resident 5 was on an anti-coagulant (medication that thins the blood). The care plan indicated as an intervention, the facility would complete lab tests as ordered and report abnormal results to the physician. During a review of Resident 5's Order Summary Report, dated 2/1/2025, the report indicated on 10/25/2024 the physician entered an order for a monthly CBC and CMP to be completed starting on 10/28/2024. (continued on next page)		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/1/2025 at 6:33 p.m. with Licensed Vocational Nurse (LVN) 6, Resident 5's physician orders and lab results were reviewed. Resident 5's physician orders indicated she was to have a CBC and CMP drawn monthly starting on 10/28/2024. Review of Resident 5's lab results indicated the CBC was last completed November 2024. LVN 6 stated the CBC should have been completed in December 2024 and January 2025. A review of Resident 5's lab results indicated the CMP was last completed June 2024. LVN 6 stated the CMP should have been completed in October 2024, November 2024, December 2024, and January 2025. LVN 6 stated the labs were ordered for ongoing monitoring of the Resident 5's health. LVN 6 stated since the tests were not completed the resident may have had a decline in health that was not noticed. The labs can identify infection. Something could have been developing, but you wouldn't know. During a review of the facility's policy and procedure (P&P) titled, Laboratory/Radiology and Other Diagnostic Services, dated August 2002, the P&P indicated the facility will provide residents laboratory and diagnostic services when ordered by the attending physician 24 hours a day, seven days a week.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49131 Based on observation, and interview, the facility failed to: 1. Keep the dry food pantry area clean and free from food debris. 2. Ensure open packages of food are sealed and closed. 3. Ensure leaking food items in the freezer are cleaned up. These deficient practices had the potential for cross-contamination and can attract pests and rodents to the area. Findings: During an observation on 2/1/2025 at 7:53 a.m. in the dry food pantry, a whitish granule substance was found on the floor underneath the shelves and on top of the lid of a container on the food shelf. During an observation on 2/1/2025 at 7:53 a.m. in the dry food pantry, one package of Pure Grade A Dried Milk was opened and placed inside a clear resealable plastic bag which was also open and had the product exposed. During an observation on 2/1/2025 at 7:59 a.m. in the kitchen, a can of opened soda and a cup with clear liquid was found on top of a desk. During an observation on 2/1/2025 at 8:04 a.m. in the kitchen, the bottom shelf of the freezer had one package of ground turkey with an already frozen red substance leaking from the packaging and spilling onto another package of ground turkey just below it. During an interview on 2/1/2025 at 6:48 p.m. with the Dietary Supervisor (DS), the DS was shown pictures taken of the areas of concern. DS stated the whitish granule substance on the floor and the container lid is possibly corn meal, salt, or sugar. The DS stated the package of dried milk should be closed and not exposed, and the can of soda and cup of clear liquid should have been discarded and not left on the desk. The DS further stated the package of ground turkey is leaking and looks like frozen blood and was leaking onto the package at the bottom and should be cleaned up or discarded. The DS stated the food storage area and kitchen need to be kept clean to prevent attracting pests or rodents to the area and can be a source of cross-contamination as well.		

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Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 48712 Based on interview and record review, the facility failed to: 1. Ensure payroll-based journal (PBJ) data was submitted to CMS quarterly as mandated by the Centers for Medicare and Medicaid Services (CMS). This deficient practice prevented CMS from knowing if the facility was meeting required staffing levels for safe/quality patient care. Findings: During a review of the PBJ Staffing Data Report, dated 1/29/2025, the report indicated for fiscal year quarter four (July-September 30) of 2024, the facility failed to submit PBJ data. During an interview on 2/01/2025 at 10:40 a.m. with the Administrator (ADM), the ADM stated he was not aware the PBJ data had not been submitted. The ADM stated the PBJ must be submitted to CMS so they can verify the facility has adequate staffing. During an interview on 2/01/2025 at 4:36 p.m. with the Director of Nursing (DON), the DON stated the PBJ should be submitted by the payroll department. The DON stated the payroll staff was not aware he was responsible for sending it. PBJ must be submitted so CMS can see if you have safe staffing for patient care.		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to: 1. Implement the antibiotic stewardship program (coordinated program that promotes the appropriate use of antibiotics by clinician) by failing to monitor and address antibiotic (a drug used to kill bacteria or to treat infection) use for one of one sampled resident (Resident 96) who was on antibiotic for pneumonia (infection of the lungs) was not evaluated upon admission to the facility. This deficient practice had the potential for Resident 96 to receive an inappropriate antibiotic and develop antibiotic resistance (when bacteria change and becomes resistant to antibiotic). Findings: During a review of Resident 96's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated, Resident 96 was admitted to the facility on [DATE]. The Admission Record indicated, Resident 96's diagnoses included pneumonia, hypertension ([HTN] - high blood pressure), and muscle weakness. During a review if Resident 96's History and Physical (H&P), dated 2/2/2025, the H&P indicated, Resident 96 did not have the capacity to understand and make decisions. During a review of Resident 96's MDS assessment, dated 1/28/2025, the MDS indicated, Resident 96's cognitive (ability to think and reason) skills for daily decision making was severely impaired. During a review of Resident 96's Order Summary Report (a document containing active orders), dated 1/24/2025, indicated Resident 96's physician prescribed levofloxacin (drug used to treat bacterial infection) once a day for two days. During a review of Resident 96's chest computed tomography ([CT] - process of taking pictures of body parts to diagnose and treat disease or injury), dated 1/20/2025, from General Acute Care Hospital (GACH), the chest CT result consistent of pneumonia. During a concurrent interview and record review on 2/1/2025 at 5:05 p.m., with the Infection Preventionist Nurse (IPN), Resident 96's clinical records were reviewed. The IPN stated he did not fill out and complete the McGeer Criteria (minimum set of signs and symptoms which when met, indicate that a resident likely has an infection and that an antibiotic might be needed) surveillance form when Resident 96 was started and completed the antibiotic. The IPN stated he did not check Resident 96's GACH records and was not informed by facility staff that Resident 96's was on antibiotic and diagnosed with pneumonia. The IPN stated he could not validate if Resident 96 meets the criteria for antibiotic since he did not complete the antibiotic surveillance form. (continued on next page)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/2/2025 at 9:57 a.m., with the Director of Nursing (DON), the DON stated completing the infection surveillance form was part of the antibiotic stewardship program of the facility in compliance with the federal requirements. The DON stated the risk for not completing the McGeer Surveillance form placed Resident 96 at risk for harm for antibiotic drug resistance since his prescribed antibiotic was not evaluated. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, dated 10/1/2023, the P&P indicated, The criteria for identifying HAI's are based on the current standard definitions of infections according to the McGeer criteria and Centers for Disease Control and Prevention (CDC) guidelines. The P&P indicated the licensed nurses will initiate the gathering of surveillance data for each resident and the Infection Preventionist will review the Infection Control Surveillance Form.		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 48712 Based on interview and record review, the facility failed to: 1. Ensure each resident had 80 sqft of living space in rooms 101, 102, 103, 104, 105, 107, 111, 112, 114, 115, 117, 201, 202, 203, 204, 205, 207, 209, 211, 212, 214, 215, 217. This deficient practice had the potential to result in residents not being able to move around freely or store personal items. Staff may also have difficulty providing care due to a lack of space. Findings: During an interview on 2/2/2025 at 3:00 pm. with the Administrator (Adm), the Adm stated he did not have a room waiver. The Adm did not provide a room waiver request letter. During a review of the Client Accommodation Analysis, dated 2/2/2025, the analysis indicated the facility had the following room measurements: Room # # of beds Dimensions Sqft per resident 101, 102, 103, 104 2 11x14 77 sqft 105, 106, 107, 111 2 11x14 77 sqft 112, 115, 114, 117 2 11x14 77 sqft 201, 202, 203, 204 2 11x14 77 sqft 205, 207, 211, 212 2 11x14 77 sqft 214, 215, 217 2 11x14 77 sqft 209 3 11x19 69 sqft		