STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555309	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sundance Creek Post Acute	5800 West Wilson Street Banning, CA 92220

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50204 Based on observation, interview, and record review, the facility failed to ensure the residents' rights were promoted and respected for six of 11 residents (Residents 23,29, 59, 106, 112 and 126) when: 1. Residents 23, 29, 59, 106 and 126 complained that call lights (devices used by residents to signal a need for assistance from facility staff) were not answered promptly by staff. This failure had the potential for Residents 23, 29, 59, 106 and 126 to not receive timely care, which could lead to falls, injuries, and worsening of residents' condition. 2. Resident 112's lunch meal tray was not served at the same time as another resident's. This failure had the potential to decrease Resident 112's meal intake, which could lead to weight loss. Findings: 1. On August 20, 2024, at 10:25 a.m., during an interview with Residents 29, 59, 106, and 126, on the Resident Council meeting. Residents 29, 59, 106, and 126 stated when they call for assistance the staff did not respond timely. The residents further stated call light response issue was previously discussed during Resident Council meetings but was not resolved. 1a. On August 20, 2024, Resident 29's ADMISSION RECORD, was reviewed. Resident 29 was admitted to the facility on [DATE], with diagnoses which included muscle weakness. A review of Resident 29's History and Physical, dated April 23, 2024, indicated Resident 29 had the capacity to understand and make decisions. On August 20, 2024, at 3:07 p.m., during an interview with Resident 29, he stated he waited 25 minutes after activation of the call light before nursing staff responded. 1b. On August 20, 2024, Resident 59's ADMISSION RECORD, was reviewed. Resident 59 was admitted to the facility on [DATE], with diagnoses which included abnormalities of mobility. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 59's History and Physical, dated June 20, 2024, indicated Resident 59 had the capacity to understand and make decisions. On August 20, 2024, at 3:00 p.m., during an interview with Resident 59, she stated the CNAs informed her that they could not respond to the call lights right away because they were busy. Resident 59 further stated it takes 10 minutes for nursing staff to respond. 1c. On August 20, 2024, Resident 106 ' s record was reviewed. Resident 106 was admitted to the facility on [DATE], with diagnoses which included history of falling. A review of Resident 106's History and Physical, dated February 22, 2024, indicated Resident 106 had the capacity to understand and make decisions. On August 20, 2024, at 3:20 p.m. during an interview with Resident 106, he stated the nursing staff would pass by his room when his call light was activated and would not respond for 15 minutes. 1d. On August 20, 2024, Resident 126's ADMISSION RECORD, was reviewed. Resident 126 was admitted to the facility on [DATE], with diagnoses which included muscle wasting (decreases strength and the ability to move). A review of Resident 126's History and Physical, dated May 16, 2024, indicated Resident 126 had the capacity to understand and make decisions. On August 20, 2024, at 3:30 p.m. during an interview with Resident 126, she stated she had to wait 30 minutes after activating the call light. 1e. On August 20, 2024, Resident 23's ADMISSION RECORD, was reviewed. Resident 23 was admitted to the facility on [DATE], with diagnoses including fracture of left fibula (broken leg bone). A review of Resident 23's History and Physical, dated May 6, 2024, indicated Resident 23 had the capacity to understand and make decisions. On August 19, 2024, at 10:57 a.m., during an interview with Resident 23, he stated he had to yell out for assistance after call light activation because he felt ignored after a delay in call light response. On August 22, 2024, at 11:10 a.m., during an interview with Registered Nurse (RN) 1, he stated, all staff should answer the call lights right away. RN 1 further stated if call lights were not answered promptly, there is a potential for residents to fall, experienced unrelieved pain, or suffer harm. On August 22, 2024, at 2:39 p.m., during an interview with the Director of Nursing (DON), she stated her expectation was for all staff to respond promptly to call lights. A review of the facility policy and procedure titled, Answering the Call Light, dated October 2010, indicated, . respond to the resident's requests and needs .Answer the resident's call as soon as possible . (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On August 20, 2024, at 12:20 p.m., an observation was conducted in the East dining room with Residents 112 and 41. Residents 41 and 112 were the only residents eating in the East dining room. Resident 41 was served a lunch meal first and began eating immediately. Resident 112 did not receive her lunch meal and was observed watching Resident 41 eat. On August 20, 2024, at 12:30 p.m., an interview was conducted with Resident 112. Resident 112 stated she and Resident 41 eat their lunch and dinner in the East dining room daily, and Resident 41 always receives her meal first. Resident 112 further stated she felt upset and left out because Resident 41 was able to enjoy her meal first. On August 21, 2024, at 9:19 a.m., an interview was conducted with the Registered Dietitian (RD). She stated that both Residents 41 and 112 should have received their meals at the same time. The RD further stated Resident 112's dignity was not honored, which had the potential to cause Resident 112 to feel upset and not enjoy her meal. A review of the facility Policy and Procedure titled, QUALITY OF LIFE -DIGNITY, dated August 2009, indicated, .Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality .Residents shall be treated with dignity and respect at all times .

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50204 Based on observation, interview, and record review, the facility failed to ensure an assessment was conducted for three of eight residents (Resident 49, 101, and 113) reviewed for safe self-administration of medication when: 1. One pink medication pill was found on the overbed table. 2. One opened bottle of 15ml (milliliters - unit of measurement) eyedrops (medication that relieved eye irritation) was found on the overbed table. 3. One opened black bottle of 15,250 MG (milligram - unit of measurement) dietary supplement was found on the overbed table. This failure had the potential for Residents 49, 101, and 113 to receive multiple doses of medication without proper monitoring, which could lead to harmful effects or death. Findings: 1. On August 19, 2024, at 8:33 a.m., during concurrent observation and interview with Resident 49 in his room, one pink medication tablet was oberved on top of his bedside table. Resident 49 stated the nurse placed the medication on his overbed table this morning and then left the room. Resident 49 further stated, I was sleepy so I did not take the medication. On August 22, 2024, Resident 49's ADMISSION RECORD, was reviewed. Resident 49 was admitted on [DATE], with diagnoses which included hypothyroidism (underactive thyroid), dysphagia (difficulty in swallowing). A review of Resident 49's Order Summary, dated April 8, 2024, indicated, Levothyroxine Sodium (medicine used to treat an underactive thyroid gland) Tablet 200 microgram (MCG - unit of measurement) .for Hypothyroidism .give .before breakfast . Further review of Resident 49's medical record indicated there was no documented evidence that a self-administration assessment was conducted. On August 19, 2024, at 11:25 a.m., during a concurrent observation and interview with Licensed Vocational Nurse (LVN) 1, he stated the pink tablet is levothyroxine and it shouldn't be left on the overbed table. LVN 1 further stated Resident 49 should have an assessment for self-administration of levothyroxine. 2. On August 19, 2024, at 8:31 a.m., during a concurrent observation and interview with Resident 101 in his room, one opened bottle of 15 ml eyedrops was on the overbed table. Resident 101 stated he administer the medication himself when he wanted to relieve irritation and itchiness. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On August 22, 2024, Resident 101's ADMISSION RECORD, was reviewed. Resident 101 was admitted on [DATE], with diagnoses which included bipolar disorder (mental illness that causes unusual shifts in a person's mood). Further review of Resident 101's medical record indicated, there was no documented evidence that a self-administration assessment was conducted. In addition, there was no physician order for the use of the eyedrops. On August 19, 2024, at 9:45 a.m., during a concurrent interview and review of Resident 101's medical records with LVN 2, she stated, Resident 101 did not have a physician's order for the eyedrop solution. LVN 2 further stated, the eyedrop solution should have had a physician order and a self-administration assessment should have been completed. 3. On August 19, 2024, at 8:35 a.m., during a concurrent observation and interview with Resident 113 in his room, one opened black bottle of dietary supplement was found on the overbed table. Resident 113 stated, he takes the medication daily and the staff were aware. On August 22, 2024, Resident 113's 'ADMISSION RECORD, was reviewed. Resident 113 was admitted on [DATE], with diagnoses which included dysphagia (difficulty swallowing). Further review of Resident 113's medical record indicated, there was no documented evidence a self-administration assessment was conducted. In addition, there was no physician order for the use of the dietary supplement. On August 19, 2024, at 8:45 a.m., during a concurrent interview and review of Resident 113's medical records with LVN 2, she stated Resident 113 had a bottle of supplement at the bedside without a physician order. LVN 2 stated, supplements should not be kept at the bedside. LVN 2 futher stated, the dietary supplement should not be taken without a physician's order and a self-administration assessment should have been conducted. On August 22, 2024, at 2:55 p.m. during an interview with the Director of Nursing (DON), she stated, her expectation for licensed nurses was to follow the policy and procedure regarding self-administration assessment and administration of medication or supplement for all residents. The DON further stated if the policy and procedures are not followed, there is a potential for residents to not receive medications according to the physician order and to not be monitored for any adverse (negative) effects. A review of policy and procedure titled, Administration Process, undated, indicated .Medications are administered in accordance with the written orders of the attending physician .Prepared drugs are not left with the resident (unless the resident has asked for, and has had approved the right of self-administration . A review of policy and procedure titled, Self-Administration of Medications dated February 2021, indicated, . Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so .Self -administered medications are stored in a safe and secure place, which is not accessible by other residents .Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44505 Based on interview, and record review, the facility failed to ensure education and resources for Advance Directive (AD - written statement of a person's wishes regarding medical treatment) was provided for 15 of 25 residents (Residents 15, 60, 82, 57, 56, 53, 87, 104, 58, 49, 105, 107, 52, 113, and 101), and or the Resident Representative (RP). This failure had the potential for Residents 15, 60, 82, 57, 56, 53, 87, 104, 58, 49, 105, 107, 52, 113, 101 and the RP not to be educated and informed about AD and the facility unable to know and honor the residents wishes regarding their medical treatment. Findings: 1. On August 20, 2024, Resident 15's 'ADMISSION RECORD, was reviewed. Resident 15 was admitted to the facility on [DATE], with diagnoses which included dementia (loss of memory). A review of Resident 15's HISTORY AND PHYSICAL EXAMINATION, dated June 6, 2024, indicated, Resident 15 did not have the capacity to understand and make decisions. A review of Resident 15's Social History Assessment, dated May 16, 2024, did not indicate Resident 15 had AD. Further review of Resident 15's medical records indicated there was no documented evidence Resident 15 and or RP were provided information and education regarding AD. 2. On August 20, 2024, Resident 60's 'ADMISSION RECORD, was reviewed. Resident 60 was admitted to the facility on [DATE]. A review of Resident 60's, HISTORY AND PHYSICAL EXAMINATION, dated July 16, 2024, indicated Resident 60 had the capacity to understand and make decisions. A review of Resident 60's Social History Assessment, dated December 6, 2023, did not indicate Resident 60 had AD. Further review of Resident 60's medical record indicated, there was no documented evidence Resident 60 and or RP were provided information and education regarding AD. 3. On August 20, 2024, Resident 82's 'ADMISSION RECORD, was reviewed. Resident 82 was admitted to the facility on [DATE]. A review of Resident 82's document titled HISTORY AND PHYSICAL EXAMINATION, dated September 27, 2023, indicated, Resident 82 is capable to make decisions about health care. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 82's, Advance Healthcare Directive Acknowledgement Form, dated February 10, 2023, indicated, .I do not have Advance Healthcare Directive . Resident 82 signed the document which indicated resident wished to be provided education regarding AD. A review of Resident 82's Social History Assessment, dated November 10, 2023, indicated, .Advance Directives .none of the above . Further review of Resident 82's medical record indicated, there was no documented evidence Resident 82 and or RP were provided information and education regarding AD. 4. On August 20, 2024, Resident 57's 'ADMISSION RECORD, was reviewed. Resident 57 was admitted to the facility on [DATE]. A review of Resident 57's, HISTORY AND PHYSICAL EXAMINATION, dated January 18, 2024, indicated Resident 57 has the capacity to understand and make decisions. A review of Resident 57's Social History Assessment, dated August 9, 2023, indicated, .Advance Directives . none of the above . Further review of Resident 57's medical records indicated, there was no documented evidence Residents 57 and or RP were provided information and education regarding AD. 5. On August 20, 2024, Resident 56's ADMISSION RECORD, was reviewed. Resident 56 was admitted to the facility on [DATE], with diagnoses which included depression (mental disorder that can affect a person's thoughts, feelings, behavior, and sense of wellbeing). A review of Resident 56's, HISTORY AND PHYSICAL EXAMINATION, dated February 18, 2024, indicated Resident 56 does not have the capacity to understand and make decisions. A review of Resident 56 Social History Assessment, dated November 28, 2023, did not indicate Resident 56 had an AD. Further review of Resident 56's medical records indicated, there was no documented evidence Resident 56 and or RP were provided information and education regarding AD. 6. On August 20, 2024, Resident 53's 'ADMISSION RECORD, was reviewed. Resident 53 was admitted to the facility on [DATE], with diagnoses which included dementia (memory loss). A review of Resident 53's, HISTORY AND PHYSICAL EXAMINATION, dated April 26, 2024, indicated Resident 53 does not have the capacity to understand and make decisions. A review of Resident 53 s Social History Assessment, dated March 14, 2024, did not indicate Resident 53 had AD. Further review of Resident 53's medical records indicated, there was no documented evidence Resident 53 and or RP were provided information and education regarding AD. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On August 20, 2024, at 12:42 p.m., during a concurrent interview and review of Residents 15, 60, 82, 57, 56 and 53's medical records with the Social Service Director (SSD), she stated Residents 15, 60, 82, 57, 56 and 53 did not have AD's and she did not provide AD education or follow up to the Residents and RP. 44270 7. On August 21, 2024, Resident 87's record was reviewed. Resident 87 was admitted to the facility on [DATE], with diagnosis which included Alzheimer's disease (memory loss). A review of Resident 87's, HISTORY AND PHYSICAL, dated June 4, 2024, indicated Resident 87 does not have capacity to understand and make decisions. A review of Resident 87's, Physician Orders for Life-Sustaining Treatment (POLST), indicated Resident 87 did not have an Advance Directive. A review of Resident 87's, Social History Review, dated June 18, 2024, did not indicate Resident 87 had an AD. Further review of Resident 87's medical records indicated that there was no documented evidence Resident 87 and or RP were provided with information and education regarding AD. On August 23, 2024, at 10:42 a.m., during a concurrent interview and review of Resident 87's medical record with the SSD, she stated if a resident did not have an AD, she would provide education and resources to formulate one. The SSD stated Resident 87 did not have AD's and she should have provided AD education or follow up to the Residents and RP. The SSD further she should have provided resources and education to Resident 87 and the RP, and she should have documented in the medical records. 47202 8. On August 22, 2024, Resident 104's 'ADMISSION RECORD, was reviewed. Resident 104 was admitted to the facility on [DATE]. A review of Resident 104's History and Physical dated May 9, 2024, indicated Resident 104 has the capacity to understand and make decisions. A review of Resident 104's Social History Review, dated June 14, 2024, indicated, .Advance Directive .None of the above . Further review of Resident 104's medical records indicated that there was no documented evidence education and information about AD was provided to Residents 104 or the RP. On August 22, 2024, at 2:42 p.m., during a concurrent interview and review of Resident 104's medical record with the SSD, she stated Resident 104 had no AD and she did not provide resources and education. The SSD further stated she should have provided resources and education to Resident 104 and the RP, and she should have documented in the medical records. 50309 (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. On August 20, 2024, Resident 58's 'ADMISSION RECORD, was reviewed. Resident 58 was admitted to the facility on [DATE]. A review of Resident 58's History and Physical, dated March 1, 2024, indicated Resident 58 has the capacity to understand and make decisions. A review of Resident 58's Physician Order for Life Sustaining Treatment (POLST - a form that documents a resident's treatment wishes in the event of a medical emergency), dated March 27, 2024, did not indicate Resident 58 had an AD. Further review of Resident 58's medical record indicated that there was no documented evidence education and information about AD was provided to Residents 58. On August 22, 2024, at 9:42 a.m., during a concurrent interview and review of Resident 58's medical record with the SSD, she stated Resident 58 had no AD and she did not provide resources, education, and follow up. The SSD further stated she should have provided resources and education to Resident 58, and she should have documented in the medical records. 50204 10. On August 20, 2024, Resident 49's 'ADMISSION RECORD, was reviewed. Resident 49 was admitted to the facility on [DATE]. A review of Resident 49's History and Physical, dated April 3, 2024, indicated Resident 49 has capacity to understand and make decisions. A review of Resident 49's Social History Assessment, dated February 27, 2024, did not indicate Resident 49 had an AD. Further review of Resident 49's medical record indicated there were no documented evidence education and information about AD were provided to Resident 49 and the RP. On August 20, 2024, at 11:37 a.m., during a concurrent interview and review of Resident 49's medical record with the SSD, she stated Resident 49 had no AD and she did not provide resources, education and follow up. The SSD further stated she should have provided resources and education, and she should have documented in the medical records. 11. On August 20, 2024, Resident 52's ADMISSION RECORD, was reviewed. Resident 52 was admitted to the facility on [DATE]. A review of Resident 52's History and Physical, dated July 27, 2022, indicated the resident has capacity to understand and make decisions. A review of Resident 52's Social History Assessment, dated June 28, 2024, did not indicate Resident 52 had an AD. Further review of Resident 52's medical record indicated, there was no documented evidence education and information about AD were provided to Resident 52 and the RP. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On August 20, 2024, at 11:37 a.m., during a concurrent interview and review of Resident 52's medical record with the SSD, she stated Resident 52 had no AD and she did not provide resources, education and follow up. The SSD further stated she should have provided resources and education, and she should have documented in the medical records. 12. On August 20, 2024, Resident 101's 'ADMISSION RECORD, was reviewed. Resident 101 was admitted to the facility on [DATE]. A review of Resident 101's History and Physical, dated August 22, 2024, indicated the resident has capacity to understand and make decisions. A review of Resident 101's Social History Assessment, dated July 13, 2023, did not indicate Resident 52 had an AD. Further review of Resident 101's medical record indicated, there was no documented evidence education and information about AD were provided to Resident 101 and the RP. On August 20, 2024, at 11:37 a.m., during a concurrent interview and review of Resident 101's medical record with the SSD, she stated Resident 101 had no AD and she did not provide resources, education and follow up. The SSD further stated she should have provided resources and education, and she should have documented in the medical records. 13. On August 20, 2024, Resident 105's ADMISSION RECORD, was reviewed. Resident 105 was admitted to the facility on [DATE]. A review of Resident 105's History and Physical, dated January 30, 2024, indicated the resident has capacity to understand and make decisions. A review of Resident 105's Social History Assessment, dated February 1, 2024, did not indicate Resident 105 had an AD. Further review of Resident 105's medical record indicated, there was no documented evidence education and information about AD were provided to Resident 105 and the RP. On August 20, 2024, at 11:37 a.m., during a concurrent interview and review of Resident 105's medical record with the SSD, she stated Resident 105 had no AD and she did not provide resources, education and follow up. The SSD further stated she should have provided resources and education, and she should have documented in the medical records. 14. On August 20, 2024, Resident 107's ADMISSION RECORD, was reviewed. Resident 107 was admitted to the facility on [DATE]. A review of Resident 107's History and Physical, dated November 8, 2023, indicated the resident has capacity to understand and make decisions. A review of Resident 107's Social History Assessment, dated November 27, 2023, did not indicate Resident 105 had an AD. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident 107's medical records indicated, there was no documented evidence education and information about AD were provided to Resident 107 and the RP. On August 20, 2024, at 11:37 a.m., during a concurrent interview and review of Resident 107's medical record with the SSD, she stated Resident 107 had no AD and she did not provide resources, education and follow up. The SSD further stated she should have provided resources and education, and she should have documented in the medical records. 15. On August 20, 2024, Resident 113's ADMISSION RECORD was reviewed. Resident 113 was admitted to the facility on [DATE]. A review of Resident 113's History and Physical, dated March 4, 2024, indicated the resident has capacity to understand and make decisions. A review of Resident 113's Social History Assessment, dated March 7, 2024, did not indicate Resident 105 had an AD. Further review of Resident 113's medical records indicated, there was no documented evidence education and information about AD were provided to Resident 113 and the RP. On August 20, 2024, at 11:37 a.m., during a concurrent interview and review of Resident 113's medical record with the SSD, she stated Resident 113 had no AD and she did not provide resources, education and follow up. The SSD further stated she should have provided resources and education, and she should have documented in the medical records. The facility policy and procedure titled Advanced Directives, dated December 2016, indicated, .Upon admission the resident will be provided with written information concerning the right to .formulate an advance directive .If the resident is .unable to receive information about .advance directive .the information may be provided to the resident legal representative .If the resident indicated that he or she has not established advance directives, the facility will offer assistance in establishing advance directives . A review of the facility document titled Job Description: Social Service Staff, dated March 2017, indicated, . Provide medically related social services so that the highest practicable physical, mental and psychosocial well being of each resident is attained of maintained .

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sundance Creek Post Acute	5800 West Wilson Street Banning, CA 92220

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50204 Based on interview and record review, the facility failed to provide a homelike environment for one of four residents reviewed for environment (Resident 107) when the resident complained of uncomfortable noise level during sleeping hours. This failure had the potential for Resident 107 to experience lack of sleep, discomfort, and irritability which could affect the resident's overall health and well-being. Findings: On August 22, 2024, Resident 107's record was reviewed. Resident 107 was admitted to the facility on [DATE], with diagnoses which included hypotension (low blood pressure). A review of Resident 107's Health Status Notes, dated August 20, 2024, at 9:19 a.m., indicated, .Two residents outside .One gardening .One sitting on bench .Today Patient states it happened again . A review of Resident 107's Care Plan, dated August 16, 2024, indicated, .Complained about another resident doing gardening early in the morning and it wakes him up . On August 19, 2024, at 10:20 a.m., during a concurrent observation and interview with Resident 107 in his room, Resident 107 was sitting in his bed with eyes closed. Resident 107 stated, he woke up early because someone was banging on the ground outside. On August 20, 2024, at 10:35 a.m., during concurrent interview and record review with License Vocational Nurse (LVN) 2, she stated Resident 107 had complained multiple times about noise during sleeping hours. LVN 2 further stated Resident 107 should have been provided a quiet and comfortable home like environment to promote rest during sleeping hours. On August 22, 2024, at 3:42 p.m., during an interview with the Director of Nursing (DON), she stated her expectation was for facility staff to maintain an acceptable noise level so that no one would be disturbed during sleeping hours. The DON further stated staff should follow the policy and procedure for homelike environment so that the residents can be free from unwanted noise during sleeping hours and promote rest. A review of facility policy and procedure titled, Quality of Life-Homelike Environment, dated May 2017, indicated, .Staff shall provide person-centered care that emphasizes resident's comfort .and personal needs . The facility staff and management shall maximize .homelike setting. These characteristics include . comfortable noise levels .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44505 Based on interview and record review, the facility failed to ensure an accurate smoking assessment was conducted for one of one resident reviewed for smoking (Resident 95), who smokes electronic cigarettes (battery powered device that heats liquids into an aerosol that users breathe in). This failure had the potential to result in Resident 95 sustaining an injury associated with the use of electronic cigarettes. Findings: On August 23, 2024, Resident 95's ADMISSION RECORD, was reviewed. Resident 95 was admitted to the facility on [DATE], with diagnoses which included pulmonary hypertension (blood pressure in the lungs higher than normal). A review of Resident 95's History and Physical Examination , dated July 12, 2024, indicated has the capacity to understand and make decisions. A review of Resident 95's Minimum Data Set (an assessment tool), dated March 18, 2024, indicated Resident 95 had a Brief Interview of Mental Status (a cognitive screening tool used to assess the mental state of residents) Score of 15 (cognitively intact.) A review of Resident 95's Smoking Observation/Assessment, dated June 13, 2024, indicated, .Resident denies smoking or use of all tobacco products . On August 20, 2025, at 11:10 a.m., during an interview with Resident 95, he stated he smokes occasionally when he is stressed and he recently smoked in a non-designated area. On August 22, 2024, at 3:32 p.m , Licensed Vocational Nurse (LVN) 14 stated, she could smell smoke on Resident 95 after he had been gardening. LVN 14 stated the staff knew the resident was smoking. On August 23, 2024, at 9:21 a.m., during an interview with the Activity Director (AD), she stated she was the person responsible for conducting resident smoking assessments. The AD further stated Resident 95 does not smoke and was not listed on the facility's list of smoker residents. The AD stated she was made aware that staff had observed Resident 95 smoking and she she should have followed up. The AD further stated she should have followed up and updated Resident 95 smoking assessment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility's Policy titled, Smoking Policy, revised date August 2022, the policy indicated, .Electronic cigarettes (e-cigarettes) are not considered smoking devices with respect to the risk of ignition, but they are considered a risk for residents related to: a. potential health effects for the smoker, such as respiratory illness or lung injury which may present with symptoms of breathing difficulty, shortness of breath, chest pain, mild to moderate gastrointestinal illness, fever or fatigue; b. second-hand aerosol exposure; c. nicotine overdose by ingestion or contact with the skin and d. explosion or fire caused by the battery .residents are permitted to use e-cigarettes with supervision and in designated areas only .Residents who wish to use e-cigarettes are assessed for their ability to safely handle the device .instructed on battery safety and tips to avoid explosions .e-cigarette safety is documented in the resident care plan .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50204 Based on observation, interview, and record review, the facility failed to provide respiratory care and treatment for one of two residents reviewed for respiratory care (Resident 52) when the physician's order for oxygen therapy was not implemented as ordered. This failure had the potential for Resident 52 to experience oxygen toxicity (harmful effects related to excessive oxygen in the lungs). Findings: On August 19, 2024, Residents 52's ADMISSION RECORD, was reviewed. Resident 52 was admitted on [DATE], with diagnoses which included other specified symptoms and signs involving circulatory (relating to the circulation of blood) and respiratory system (system allow oxygen in the air to be taken in and out of the body). A review of Resident 52's care plan dated July 2, 2024, indicated .Potential for SOB (shortness of breath) . Interventions .Oxygen at 2L/min . A review of Resident 52's Order Summary, dated, August 19, 2024, indicated, .Oxygen .at 2 L/min (LPM -liters per minute) via NC (nasal cannula - a plastic tubing that delivers oxygen through the nose) .for SOB (shortness of breath) . On August 19, 2024, at 11 a.m., during a concurrent observation and interview with Resident 52 in his room, Resident 52 was on oxygen via NC at a flow rate of four LPM. Resident 52 stated, the air was too strong, and I feel I'm drowning. On August 19, 2024, at 11:40 a.m., during a concurrent observation and interview inside Resident 52's room with Licensed Vocational Nurse (LVN) 1, he stated the oxygen flow rate was set to four LPM. LVN 1 further stated Resident 52's oxygen flow rate should have been set at 2 LPM. On August 22, 2024, at 8:40 a.m., during a concurrent interview and record review with Registered Nurse (RN) 1, he stated Resident 52 should have received oxygen at a flow rate of two LPM. RN 1 further stated an increased flow rate of oxygen not accordance with the physician order had the potential to cause oxygen toxicity. A review of the facility policy and procedure titled, Oxygen Administration dated October 2010, indicated, .to provide guidelines for safe oxygen administration .verify .physician's order .

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50204 Based on observation, interview, and record review, the facility failed to ensure for 20 of 20 residents reviewed for pain (Resident 3, 16, 18, 19, 23, 26, 30, 34, 58, 65, 76, 80, 83, 88, 95, 98, 99, 120, 278, 280): a. A pain assessment was conducted prior to the administration of PRN narcotic pain medication; and b. An evaluation was conducted after the administration of PRN narcotic pain medication. These failures had the potential for Residents 18, 58, 65, 19, 278, 23, 26, 34, 83, 99, 120, 76, 88, 95, 16, 80, 280, 3, 30, and 98, to experience unrelieved and unmanaged pain which could compromise the resident's overall health and wellbeing. In addition, failing to document the residents' pain levels before and after administration of the pain medication could disrupt effective pain management and result in a lack of individualized care. Findings 1. On August 20, 2024, Resident 18's ADMISSION RECORD, was reviewed. Resident 18 was admitted to the facility on [DATE], with diagnoses which included osteomyelitis of vertebra (swelling of the bone or back bone), and diverticulosis of large intestine (small pouches in the wall of intestines). A review of Resident 18's Order Summary Report, included a physician's order, dated May 17, 2024, indicated, Tramadol HCL (hydrochloride) Tablet (narcotic pain medication) 50 MG (milligram) .Give 1 (one) tablet by mouth every 6 (six) hours as needed for Pain Moderate to severe pain . A review of Resident 18's Medication Count Sheet, for the month of August 2024, indicated that seven doses of Tramadol were signed out by the licensed nurse on the following dates and time: -August 4, 2024, at 8 p.m. -August 5, 2024, at 5:10 p.m. -August 6, 2024, at 9 a.m. -August 8, 2024, at 5 p.m. -August 9, 2024, at 6 p.m. -August 11, 2024, at 9 p.m.; and -August 15, 2024, at 2 p.m. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 18's Electronic Medication Administration Record (eMAR), from August 1, 2024, to August 20, 2024, did not indicate the LN conducted an assessment prior to administering Tramadol HCL 50 mg, nor did it show that the LN monitored and evaluated Resident 18 for the effectiveness of the pain medication, when the Tramadol HCL 50 mg was signed out from the Medication Count Sheet on those dates. On August 20, 2024, at 5:08 p.m., an interview and a concurrent review of Resident 18's progress notes from August 1, 2024, to August 20, 2024 and August eMAR were conducted with Licensed Vocational Nurse (LVN) 3. LVN 3 stated there was no documentation in Resident 18's medical record indicating the LN conducted a pain assessment prior to administering the PRN Tramadol HCL 50 mg. In addition, LVN 3 stated there was no documentation showing the LN evaluated Resident 18 after the PRN Tramadol medication was administered. On August 21, 2024, at 9:45 a.m., an interview and a concurrent review of Resident 18's progress notes from August 1, 2024, to August 20, 2024 and August eMAR were conducted with LVN 9. LVN 9 stated he was the LN who signed out the Tramadol HCL 50 mg from the medication count sheet on August 11, 2024, at 9 p.m. LVN 9 stated he administered the medication to Resident 18 but did not assess the resident prior to giving the pain medication, and evaluate Resident 18 after the administration of the PRN Tramadol HCL 50mg. LVN 9 stated he should have assessed Resident 18's pain prior to the administration of Tramadol, and should have monitored and evaluated the resident after administering the PRN Tramadol. On August 21, 2024, at 10:15 a.m., a concurrent interview and review of Resident 18's medication count sheet were conducted with LVN 1. He stated he was the LN who signed out Tramadol HCL 50 mg from Resident 18's medication count sheet on August 6, 2024, at 9:00 a.m., and August 8, 2024, at 6:00 p.m. LVN 1 stated he administered the medication to Resident 18 but did not assess the resident prior to giving the pain medication, offer non-pharmacological interventions, monitor, and evaluate Resident 18 after the administration of the PRN Tramadol HCL 50mg. LVN 1 stated he should have assessed Resident 18's pain prior to administration, and evaluated the resident after administering the PRN Tramadol 2. On August 22, 2024, Resident 58's ADMISSION RECORD, was reviewed. Resident 58 was admitted to the facility on [DATE], with diagnoses which included muscle wasting (reduced muscle strength), atrophy (declining/deteriorating of a body part or tissue), and polyneuropathy (disease affecting the function of multiple nerves [tiny wires that receives and sends messages between the body and the brain]). A review of Resident 58's Order Summary Report, included a physician's order, dated July 15, 2024, for oxycodone-acetaminophen (narcotic pain medication) 5-325mg tablet to be given by mouth every six hours PRN for moderate or severe pain. A review of Resident 58's Medication Count Sheet, for the month of August 2024, indicated that eight doses of oxycodone-acetaminophen were signed out by the licensed nurse on the following dates and time: -August 2, 2024, at 2:10 p.m. -August 5. 2024, at 4 a.m. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-August 5, 2024, at 8 p.m. -August 6, 2024, at 8 p.m. -August 10, 2024, at 2 p.m. -August 13, 2024, at 4 p.m. -August 14, 2024, at 9 p.m.; and -August 17, 2023, at 8:30 a.m. Further review of Resident 58 progress notes from August 2, 2024 to August 17, 2024, and August eMAR did not indicate the LN conducted an assessment prior to administering oxycodone-acetaminophen nor did it show the LN monitored and evaluated Resident 58 on the effectiveness of the pain medication, when oxycodone-acetaminophen was signed out from the Medication count Sheet on the above dates. On August 22, 2024, at 3:25 p.m., a concurrent interview and review of Resident 58's Medication Count Sheet, for the month of August 2024, were conducted with LVN 7. LVN 7 stated the facility's process for administering PRN narcotic pain medications required the licensed nurse to assess the resident, check the order, sign out the medication from the narcotic count sheet, enter the pain level in the eMAR, administer the medication, and follow up in an hour to reassess the resident. LVN 7 stated he signed out the oxycodone-acetaminophen 5-325mg on Resident 58's medication count sheet but did not document the administration in the eMAR. LVN 7 stated he should have assessed the resident, and it was important to assess the resident to determine the level of pain and to make sure the correct dose was given according to the physician's order. LVN 7 stated it was important to assess and document the pain level to confirm the medication's effectiveness. LVN 7 stated he should have documented the pain assessment in Resident 58's eMAR. 3. On August 22, 2024, Resident 65's 'ADMISSION RECORD, was reviewed. Resident 65 was admitted to the facility on [DATE], necrotizing fasciitis (bacterial infection of tissue under the skin) and polyneuropathy (disease affecting peripheral nerves). A review of Resident 65's Order Summary Report, included a physician's order, dated April 7, 2024, which indicated oxycodone-acetaminophen 10-325mg tablet to be given every six hours for pain management, and one tablet every four hours as needed for severe to very severe pain. A review of Resident 65's Medication Count Sheet, for the month of August 2024, indicated seven doses of oxycodone-acetaminophen 10-325mg were signed out by the LN on the following dates and times: -August 16, 2024, at 9 a.m. -August 17, 2024, at 9 a.m. -August 17, 2024, at 3 p.m. -August 17, 2024, at 9 p.m. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-August 18, 2024, at 4 p.m. -August 18, 2024, at 9 p.m.; and -August 19, 2024, at 9 p.m. Further review of Resident 65's progress notes from August 16 to 20, 2024, and August eMAR did not have documented evidence the LN conducted a pain assessment prior to the administration of Resident 65's pain medication, nor did it show that the LN monitored and evaluated Resident 65 after the PRN pain medication was administered. On August 22, 2024, at 3:40 p.m., a concurrent interview and review of Resident 65's progress notes from August 16 to 20, 2024, and the eMAR were conducted with LVN 8. During the interview, LVN 8 stated he signed out the oxycodone-acetaminophen 10-325mg from the medication count sheet but did not document a pain assessment when he administered oxycodone-acetaminophen to Resident 65. LVN 8 stated he should have documented pain assessment, administration, and evaluation of Resident 65's pain. LVN 8 stated it was important to assess and document to know if the medication was effective for the resident and to make sure the resident was not double-dosed. 4. On August 22, 2024, Resident 19's ADMISSION RECORD, was reviewed. Resident 19 was admitted to the facility on [DATE], with diagnoses which included, pain in both knees. A review of Resident 19's Order Summary Report, included a physician's order, dated June 16, 2024, which indicated, Norco Oral Tablet (hydrocodone-acetaminophen - a narcotic pain medication) 10-325MG .Give 1 (one) tablet by mouth every 12 hours as needed for Pain Management . A review of Resident 19's Medication Count sheet, for the month of August 2024, indicated three doses of hydrocodone-acetaminophen 10-325 mg were signed out by the LN on the following dates and times: August 9, 2024, at 9 a.m. August 10, 2024, at 8 p.m. August 11, 2024, at 9 p.m. Further review of Resident 19's progress notes from August 9 to 11, 2024 and August eMAR did not show documented evidence the LN conducted a pain assessment prior to the administration of the pain medication, nor the resident was monitored and evaluated after the PRN pain medication was administered. On August 22, 2024, at 10:59 a.m., during a concurrent interview and review of Resident 19's medication count sheet and the progress notes from August 9 to 11, 2024, with LVN 1, LVN 1 stated, there was no documentation pain assessment was conducted prior to and after administration of the pain medication. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On August 22, 2024, Resident 278's ADMISSION RECORD, was reviewed. Resident 278 was admitted to the facility on [DATE], with diagnoses which included, idiopathic neuropathy (nerve pain with no obvious underlying cause). A review of Resident 278's Order Summary Report, included a physician's order, dated August 1, 2024, which indicated, oxycodone-acetaminophen oral Tablet 10-325 MG .Give 1 (one) tablet by mouth every 4 (four) hours as needed for pain management . A review of Resident 278's Medication Count Sheet, for the month of August 2024, indicated four doses of oxycodone-acetaminophen were signed out by the LN on the following dates and times: -August 17, 2024, at 10:20 a.m. -August 17, 2024, at 2:30 p.m. -August 17, 2023, at 7:30 p.m.; and -August 18, 2023, at 5:30 p.m. Further review of Resident 278's progress notes from August 17 to 18, 2024, and August eMAR did not indicate the LN conducted a pain assessment prior to administering oxycodone-acetaminophen, nor that pain was monitored, and the effectiveness of the pain medication was evaluated after administration. On August 22, 2024, at 10:59 a.m., an interview and review of Resident 278's progress notes from August 17 to 18, 2024, and August eMAR were conducted with LVN 1. LVN 1 stated there was no documentation of a pain assessment conducted before and after the administration of the pain medication. 50309 6. On August 21, 2024, Resident 23's ADMISSION RECORD, was reviewed. Resident 23 was admitted to the facility on [DATE], with diagnoses which included end-stage renal disease (ESRD - when the kidneys stop working) on hemodialysis (special procedure done by a trained professional to remove wastes and excess fluids from the body) and fracture (broken bone) on left fibula (long bone in the lower extremity) bone. A review of Resident 23's History and Physical, dated April 22, 2024, indicated Resident 23 had the capacity to understand and make decisions. A review of Resident 23's care plan, dated April 22, 2024, indicated, .Focus: Pain .experiencing pain or discomfort .Goal: pain will be relieved .Interventions .give 1 tablet Tramadol 50mg by mouth every 6 hours as needed for moderate and severe pain (PS [pain scale] 3-8) .assess pain every shift and as indicated . A review of Resident 23's Order Summary Report, included a physician's order, dated May 6, 2024, indicated to give Tramadol HCL 1 tablet 50 mg by mouth every six hours as needed for moderate to severe pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 23's Medication Count Sheet, for the month of August 2024, indicated eleven doses of Tramadol HCL were signed out by the Licensed Nurse (LN) on the following dates and times: - August 2, 2024, at 9 p.m. - August 6, 2024, at (time illegible). - August 8, 2024, at 12 p.m. - August 8, 2024, at (time illegible). - August 9, 2024, at 8:05 a.m., 6 p.m., and 9:30 p.m. - August 13, 2024, at (time illegible). - August 14, 2024, at 12 p.m. and 6 p.m. -August 15, 2024, at 10 a.m.; and - August 16, 2024, at 8:00 a.m. There was no documented evidence the Licensed Nurses (LN) conducted an assessment prior to administering the Tramadol HCL 50 mg to Resident 23. In addition, there was no documented evidence the LN monitored and evaluated Resident 23 after the PRN medication was administered. On August 20, 2024, at 5:55 p.m., an interview with a concurrent record review was conducted with LVN 12. LVN 12 stated the LN signed out the tramadol HCL 50 mg from the Medication Count Sheets 1 and 2 on August 2, 6, 8, 9, 13, 14, 15, and 16, 2024. LVN 12 stated there was no documentation the LN conducted pain assessment prior to administering the Tramadol HCL 50 mg to Resident 23. LVN 12 further stated there was no documentation the LN monitored and evaluated Resident 23 after the PRN medication was administered on the dates it was signed out from the Tramadol Medication Count sheets. LVN 12 stated he was the LN who signed out Resident 23's Tramadol 50 mg on August 14, 2024, at 6:00 p.m. LVN 12 stated there was no documentation in Resident 23's medical record that he conducted pain assessment prior to administering the PRN Tramadol HCL 50 mg. In addition, LVN 12 stated there was no documentation he had monitored and evaluated Resident 23 after the PRN medication was administered. On August 21, 2024, at 10:52 a.m., an interview with Resident 23 was conducted. Resident 23 stated he took Tramadol for pain as needed. Resident 23 stated the nurses were good with getting him his pain medication, but they did not ask what his pain level was before or after they administer the pain medications. 7. On August 21, 2024, Resident 26's ADMISSION RECORD,was reviewed. Resident 26 was admitted to the facility on [DATE], with diagnoses which included chronic pain syndrome (persistent pain that lasts weeks to years) and lower back pain. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sundance Creek Post Acute	5800 West Wilson Street Banning, CA 92220

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 26's care plan, dated April 25, 2023, indicated, .Potential for alteration in comfort secondary to pain .Goal: pain will be relieved .Interventions .Assess pain symptoms .Identify frequency, location, quality, onset and manner of expressing pain .Tramadol 50mg by mouth every 6 hours as needed for severe and very severe pain . A review of Resident 26's History and Physical, dated April 27, 2024, indicated Resident 26 had the capacity to understand and make decisions. A review of Resident 26's Order Summary Report, included a physician's order, dated May 6, 2024, which indicated to give Tramadol HCL 1 tablet 50 mg by mouth every six hours as needed for moderate to severe pain. A review of Resident 26's Medication Count Sheet, for the month of July 2024, indicated two doses of Tramadol were signed out by the LN on the following dates and times: - July 10, 2024, at 5 p.m.; and - July 27, 2024, at 5 p.m. Further review of Resident 26's medical record indicated there was no documented evidence the LN conducted an assessment prior to administering the Tramadol HCL 50 mg to Resident 26. In addition, there was no documented evidence the LN monitored and evaluated Resident 26 after the PRN medication was administered. On August 20, 2024, at 5:55 p.m., an interview with a concurrent review of Resident 23's progress notes from July 10 to July 27, 2024, were conducted with LVN 9. LVN 9 stated the LN signed out the Tramadol HCL 50 mg from Resident 26's Medication Count sheet on July 10 and 27, 2024, at 5 p.m. LVN 9 stated there was no documentation if the LN conducted pain assessment prior to administering the Tramadol HCL 50 mg to Resident 26. LVN 9 stated there was no documentation the LN monitored and evaluated Resident 26 after the PRN pain medication was administered on the dates it was signed out from the Tramadol Medication Count sheet. LVN 9 stated he was the LN who signed out Resident 26's Tramadol 50 mg on July 27, 2024, at 5 p. m. LVN 9 stated there was no documentation in Resident 26's medical record that he conducted a pain assessment prior to administering the PRN Tramadol HCL 50 mg. In addition, LVN 9 stated there was no documentation that he had monitored and evaluated Resident 26 after the PRN medication was administered. On August 21, 2024, at 10:03 a.m., an interview with Resident 26 was conducted. Resident 26 stated she took Tramadol for pain as needed. Resident 26 stated the LN ask what her pain level was, but they do not do a follow up to check if the Tramadol was effective or not. 8. On August 21, 2024, Resident 34's ADMISSION RECORD, was reviewed. Resident 34 was admitted to the facility on [DATE], with diagnoses that included contusion (bruise caused by bleeding under the skin due to an injury) of the head and osteoarthritis (bone pain). A review of Resident 34's History and Physical, dated May 6, 2024, indicated Resident 34 had the capacity to understand and make decisions. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 34's Order Summary Report, included a physician's order, dated May 31, 2024, which indicated the following: - hydrocodone-acetaminophen 10-325 mg 1 tablet every 4 hours for severe to very severe pain; and - hydrocodone-acetaminophen 5-325 mg every 4 hours as needed for moderate pain. A review of Resident 34's care plan, dated May 6, 2024, indicated, .Focus: experiencing pain or discomfort due to recent fall .hematoma (bruise caused by an injury and blood collects under the skin) .arthritis (swelling and tenderness in one of more joints causing joint pain .Goal: Potential for alteration in comfort secondary to pain .Goal: pain will be relieved .Interventions .administer pain medications are ordered .monitor for side effects and notify physician if ordered .assess pain every shift and as indicated .assess for non-verbal indicators of pain .position for comfort . A review of Resident 34's Medication Count Sheet, for the month of August 2024, indicated ten doses of hydrocodone-acetaminophen 10-325 mg were signed out by the Licensed Nurse (LN) on the following dates: - August 15, 2024, at 4 a.m. - August 15, 2024, at 3 p.m. - August 15, 2024, at 7 p.m. - August 16, 2024, at 11 a.m. - August 16, 2024, at 3 p.m. - August 16, 2024, at 7 p.m. - August 16, 2024, at 11 p.m. - August 17, 2024, at 8 a.m. - August 17, 2024, at 3:30 p.m.; and - August 20, 2024, at 4:15 a.m. A review of Resident 34's Medication Count Sheet, for the month of August 2024, indicated nine doses of hydrocodone-acetaminophen 5-325 mg 1 tablet was signed out by the Licensed Nurse (LN) on the following dates: - August 15, 2024, at 8 a.m. - August 15, 2024, at 12 p.m. - August 16, 2024, at 2 p.m. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- August 17, 2024, at 4:10 a.m. - August 17, 2024, 11:30 a.m. - August 17, 2024, at 5:30 p.m. - August 18, 2024, at 6:30 p.m. - August 19, 2024, at 3:50 a.m.; and - August 19, 2024, at 9 p.m. Further review of Resident 34's record, indicated there was no documented evidence the LN conducted pain assessment prior to administering the hydrocodone-acetaminophen 10-325 mg and 5-325 mg to Resident 34. In addition, there was no documented evidence the LN monitored and evaluated Resident 34 after the PRN pain medication was administered. On August 21, 2024, at 10:38 a.m., an interview and a concurrent review of Resident 34's progress notes from August 15 to August 20, 2024, were conducted with LVN 12. LVN 12 stated the LN signed out the hydrocodone-acetaminophen 10-325 mg from the Medication Count Sheet on multiple dates in August 2024. LVN 12 stated there was no documentation the LN conducted pain assessment prior to administering the hydrocodone-acetaminophen 10-325 and 5-325 mg to Resident 34. LVN 12 stated there was no documentation the LN monitored and evaluated Resident 34 after the PRN medication was administered on the dates it was signed out from both medication count sheets 1 and 2. LVN 12 stated he was the LN who signed out Resident 34's hydrocodone-acetaminophen 10-325 on August 15 (at 3:00 p.m. and 7:00 p.m.) and 16 (at 3:00 p.m. and 7:00 p.m.), 2024 from the medication count sheet (1). LVN 12 stated there was no documentation in Resident 34's medical record that he conducted pain assessment prior to administering the PRN hydrocodone-acetaminophen 10-325 mg to Resident 34. In addition, LVN 12 stated there was no documentation the LN monitored and evaluated Resident 34 after the PRN medication was administered. LVN 12 stated he should have assessed and evaluated the resident before and after giving his PRN pain medication. On August 21, 2024, at 10:13 a.m., an interview with Resident 34 was conducted. Resident 34 stated she took Norco (brand name for hydrocodone-acetaminophen) for pain as needed. Resident 34 stated the LN would sometimes ask what her pain level was but no on one checked on her after giving the pain medication. 9. On August 21, 2024, Resident 83's ADMISSION RECORD, was reviewed. Resident 83 was admitted to the facility on [DATE], with diagnoses which included neuralgia (pain caused by damaged nerves), chronic pain, and muscle weakness. A review of Resident 83's History and Physical, dated August 30, 2024, indicated Resident 83 had the capacity to understand and make decisions. A review of Resident 83's Order Summary Report, included a physician's order, dated August 20, 2022, which indicated to give hydrocodone-acetaminophen 10-325 mg 1 tablet by mouth every 4 hours as needed for severe to very severe pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 83's care plan, dated May 6, 2024, indicated, .Focus: Potential for alteration in comfort secondary to pain .Goal: resident will be comfortable and be able to participate with ADL's (Activities of Daily Living) and rehabilitation program .Interventions .administer pain medications are ordered .assess pain symptoms .Identify frequency, location, quality, onset and manner of expressing pain . A review of Resident 83's Medication Count Sheet, for the month of July 2024 and August 2024, indicated 11 doses of hydrocodone-acetaminophen 10-325 mg were signed out by the Licensed Nurses on the following dates: - July 3, 2024, at 10 p.m. - July 6, 2024, at 11 p.m. - July 9, 2024, at 12 a.m. - July 17, 2024, at 7 p.m. - July 20, 2024, at 8 p.m. - July 22, 2024, at 9 p.m. - July 24, 2024, at 6 p.m. - August 5, 2024, at 7 p.m. - August 7, 2024, 9 p.m. - August 11, 2024, 9 a.m.; and - August 14, 2024, at 8 p.m. Further review of Resident 83's progress notes, from July 3, 2024 to August 14, 2024, indicated there was no documented evidence the LN conducted pain assessment prior to administering the hydrocodone-acetaminophen 10-325 mg to Resident 83. In addition, there was no documented evidence the LN evaluated Resident 83 after the PRN pain medication was administered. On August 21, 2024, at 10:42 a.m., an interview with a concurrent review of Resident 83's progress notes were conducted with LVN 2. LVN 2 stated the LN signed out the hydrocodone-acetaminophen 10-325 mg from Resident 83's Medication Count Sheet on the above dates and time. LVN 2 stated there was no documentation in Resident 83's medical record the LNs conducted pain assessment prior to administering the PRN hydrocodone-acetaminophen 10-325 mg and evaluated Resident 83 after administering the narcotic pain medication. On August 21, 2024, at 10:59 a.m., an interview with Resident 83 was conducted, Resident 83 stated she took Norco (brand name of hydrocodone-acetaminophen) as needed when she had pain. Resident 83 stated the LN do not offer non-pharmacological interventions before giving the PRN Norco. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. On August 21, 2024, Resident 99's ADMISSION RECORD, was reviewed. Resident 99 was admitted to the facility on [DATE], with diagnoses which included osteoarthritis (bone pain), pain in right hip, chronic pain syndrome, muscle spasm (muscle cramps), and neuralgia (pain caused by damaged nerves). A review of Resident 99's care plan, dated June 30, 2023, indicated, .Focus: Potential for alteration in comfort secondary to PAIN .Goal: Resident will be comfortable and be able to participate with ADL's . Interventions .Administer pain medications as ordered .Assess pain symptoms .Identify frequency, location, quality, onset and manner of expressing pain . A review of Resident 99's Order Summary Report, included a physician's order, dated May 16, 2024, indicated to give 1 tablet hydrocodone-acetaminophen 10-325 mg give 1 tablet by mouth every 6 hours for severe to very severe pain. A review of Resident 99's History and Physical, dated August 5, 2024, indicated Resident 99 was able to make needs known and make medical decisions. A review of Resident 99's Medication Count Sheet, for the month of August 2024, indicated eight doses of hydrocodone-acetaminophen 10-325 mg were signed out by the LN on the following dates: - August 16, 2024, at 8 a.m. - August 16, 2024, at 9 p.m. - August 17, 2024, at 8:22 a.m. - August 17, 2024, at 6 p.m. - August 18, 2024, at 9 p.m. - August 19, 2024, at 3:40 p.m. - August 19, 2024, at 11 p. m.; and - August 20, 2024, at 9 p.m. Further review of Resident 99's progress notes, from August 16, 2024 to August 20, 2024, indicated there was no documented evidence the LN conducted pain assessment prior to administering the hydrocodone-acetaminophen 10-325 mg to Resident 83. In addition, there was no documented evidence the LN evaluated Resident 83 after the PRN pain medication was administered. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On August 21, 2024, at 10:03 a.m., an interview and a concurrent review of Resident 99's progress notes were conducted with LVN 2. LVN 2 stated the LN signed out the hydrocodone-acetaminophen 10-325 mg from the Medication Count Sheet of Resident 99 on the above dates. LVN 2 stated there was no documentation in Resident 99's medical record that the LN conducted pain assessment prior to administering the PRN hydrocodone-acetaminophen 10-325 mg. In addition, LVN 2 stated there was no documented evidence the LNs evaluated Resident 99 after the PRN narcotic pain medication was administered. LVN 2 stated she did not follow the facility's process of managing pain and it placed residents at risk of having unrelieved pain. LVN 2 stated LNs should have assessed and evaluated the resident before and after giving his PRN pain medication. 11. On August 21, 2024, Resident 120's record was reviewed. Resident 120 was admitted to the facility on [DATE], with diagnoses including intervertebral disc degeneration (damaged flat, round cushions located between each vertebra in the spine causing pain), surgical aftercare following a craniotomy (surgery of the brain). A review of Resident 120's History and Physical, dated July 11, 2024, indicated Resident 120 had the capacity to understand and make decisions. A review of Resident 120's Order Summary Report, included the following physician's order: - Oxycodone HCL (narcotic pain medication) 5 MG 1 tablet by mouth every 4 (four) hours for moderate pain . date ordered July 10, 2024; and -Oxycodone 10 MG Give 1 (one) tablet by mouth every 4 (four) hours as needed for severe pain ., date ordered July 10, 2024. A review of Resident 120's care plan, dated July 11, 2024, indicated, .Pain: At risk for pain and discomfort due to general body .Will express/exhibit pain relief after .administration of medication as needed . Interventions .Administer medication as ordered .Please continue to assess pain .before giving PRN (as needed) pain med . A review of Resident 120's Medication Count Sheet, for the month of July 2024, indicated 14 doses of Oxycodone HCL 10 mg were signed out by the LN on the following dates and times: - July 11, 2024, at 12 p.m. - July 11, 2024, at 5:30 p.m. - July 11, 2024, at 10 p.m. - July 13, 2024, at 4:30 p.m. - July 13, 2024, 9 p.m. - July 14, 2024, at 4 a.m. - July 14, 2024, at 10 p.m. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- July 15, 2024, at 9 a.m. -July 16, 2024, at 9 a.m. - July 16, 2024, at 1 p.m. - July 17, 2024, at 4:30 a.m. - July 18, 2024, at 4:30 p.m. - July 21, 2024, at 9 p.m.; and - August 2, 2024, at 9 p.m. A review of Resident 120's Medication Count Sheet, indicated Oxycodone HCL 5 mg was signed out by the LN on the following dates and times: - July 13, 2024, at 1:08 a.m. - July 14, 2024, at 8:12 a.m. - July 14, 2024, at 12 p.m.; and - July 14, 2024, at 5 p.m. Further review of Resident 120's progress notes, from August 16, 2024 to August 20, 2024, indicated there was no documented evidence the LN conducted pain assessment prior to administering the hydrocodone-acetaminophen 10-325 mg to Resident 120. In addition, there was no documented evidence the LN evaluated Resident 120 after the PRN pain medication was administered. On August 21, 2024, at 10:15 a.m., an interview and a concurrent review of Resident 120's progress notes from July 11, 2024 to August 2, 2024, was conducted with LVN 2. LVN 2 stated she was the LN who signed out Resident 120's Oxycodone HCL 10 mg six (6) times during the month of July 2024. In addition, LVN 2 stated she also signed out Oxycodone HCL 5mg three (3) times during the month of July 2024. LVN 2 stated there was no documentation in Resident 120's medical record that the LN conducted pain assessment prior to administering the PRN Oxycodone HCL 10 mg and 5mg on the above dates. In addition, LVN 2 stated there was no documentation she evaluated Resident 120 after the PRN pain medication was administered to Resident 120. LVN 2 stated she did not follow the facility's process of managing pain and it placed residents at risk of not having unrelieved pain. LVN 2 stated she should have assessed and evaluated the resident before and after giving his PRN pain medication. On August 21, 2024, at 11:28 a.m., an interview with Resident 120 was conducted, Resident 120 stated she took Oxycodone for pain as needed. Resident 120 stated the LNs did not ask her pain level after the oxycodone was given to her. 44505 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12. A review of Resident 76's ADMISSION RECORD, indicated Resident 76 was admitted to the facility on [DATE], with diagnosis which included spinal stenosis (narrowing of the [TRUNCATED]

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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** 50309 Based on interview and record review, the facility failed for two of three residents reviewed for dialysis (special procedure done by a trained professional to remove wastes and excess fluids from the body) (Residents 100 and 23) to ensure: 1. Resident 100 was assessed after dialysis; and 2. Resident 23's recommendation to discontinue fluid restriction (limited fluid consumption) was followed. In addition, Resident 23's Intake and Output (I&O) were monitored. These failures had the potential for Residents 100 and 23 to not be monitored which could lead to dialysis complications (e.g. heart failure, fluid overload, bleeding), harm and or death. Findings: 1. On August 19, 2024, Resident 100's ADMISSION RECORD, was reviewed. Resident 100 was admitted to the facility on [DATE] with diagnoses which included end-stage renal disease (ESRD - when the kidneys stop working) on dialysis. A review of Resident 100's Order Summary, date June 21, 2024, indicated, .Hemodialysis (a type of dialysis) .On Tues (Tuesday), Thursday, Saturday .2 1/2 (two and a half) hour treatments . A review of Resident 100's Care Plan, dated August 1, 2023, indicated, .Monitor .symptoms of complications . Monitor for edema, chest pain, signs and symptoms of infection, nausea or vomiting, elevated blood pressure, or shortness of breath . A review of Resident 100's Pre and Post Dialysis Communication Form, dated August 17, 2024, did not indicate a post dialysis assessment after Residnet 100 return to the facility from his Hemodialysis appointment. On August 19, 2024, at 3:23 p.m., during a concurrent interview and review of Resident 100's medical records with Licensed Vocational Nurse (LVN) 2, she stated the process for dialysis is before and after dialysis, the resident will be assessed by a licensed nurse, and the assessment will be documented in the pre (before) and post (after) dialysis communication form. LVN 2 further stated Resident 100 was not assessed after his Hemodialysis treatment on August 17, 2024. LVN 2 further stated Resident 100 should have been assessed by the licensed nurse (LN) to ensure the resident was monitored for dialysis complications. On August 19, 2024, at 3:35 p.m., during a concurrent interview and review of Resident 100's medical records with the Director of Nursing (DON), she stated Resident 100 was not assessed after his Hemodialysis treatment on August 17, 2024 by the LN. The DON further stated Resident 100 should have been asessed to ensure resident safety and to monitor dialysis complications. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility's policy and procedure titled, Hemodialysis Access Care, dated September 2010, indicated, .The general medical nurse should document in the resident's medical record every shift as follows .location of catheter .condition of dressing (interventions if needed) .if dialysis was done during shift .any part of report from dialysis nurse post-dialysis being given .observations post-dialysis . 36684 2. On August 19, 2024, at 10:30 a.m., an observation and concurrent interview were conducted with Resident 23. Resident 23 was observed in bed, alert, and interviewable. There was no water pitcher observed next to Resident 23's bedside. In a concurrent interview, Resident 23 stated he was on a fluid restriction because he undergoes dialysis three times a week. Resident 23 stated he sometimes did not drink the fluids in his meal tray such as hot chocolate or fruit punch and only asks for ice chips when he feels thirsty. On August 19, 2024, at 10:50 a.m., an observation and concurrent interview were conducted with Certified Nursing Assistant (CNA) 1. A green dot sticker was observed next to Resident 23's name on the door. CNA1 stated the sticker indicated to the staff, Resident 23 was on a fluid restriction. CNA 1 stated Resident 23 goes to dialysis and is on a fluid restriction, which is why Resident 23 did not have a pitcher at his bedside. On August 20, 2024, at 11:34 a.m., an observation and concurrent interview were conducted with CNA 2. CNA 2 stated Resident 23 is on fluid restriction which is why he did not have a water pitcher by his bedside and he can only receive a cup of water. CNA 2 stated Resident 23 did not usually ask for water but sometimes requests ice chips. On August 20, 2024, Resident 23's record was reviewed. Resident 23 was admitted to the facility on [DATE], with diagnoses including End Stage Renal Disease (ESRD), diabetes (disease that result in too much sugar in the blood), and dependence on renal dialysis. The History and Physical, dated May 6, 2024, indicated, Resident 234 had the capacity to understand and make decisions. The physician's order dated April 20. 2024, indicated to monitor Resident 23's intake and output every shift due to ESRD. The following medication administration record indicated the LN did not document Resident 23's I&O information on the following dates: - The eMAR dated June 1 to 30, 2024, indicated the LN did not document I&O monitoring information on June 1 (Evening shift), June 4 (Night shift), and June 9 (Day shift); - The eMAR dated July 1 to 33, 2024, indicated, the LN did not document I&O monitoring information on July 3 (Day shift), July 11 (Night shift), July 13 (Evening shift), July 18 and 19 (Day shift), July 25 and 31 (Evening Shift); and - The eMAR dated August 1 to 31, 2024, indicated the LN did not document Resident 23's I&O on June 12 (Day Shift). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sundance Creek Post Acute	5800 West Wilson Street Banning, CA 92220

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician's order dated June 21, 2024, indicated to discontinue the 1200 ML (milliliter - unit measurement) fluid restriction. The progress notes electronically signed by the Registered Dietitian (RD) dated June 20, 2024, indicated, . RD Monthly Dialysis Communication Note .Res (Resident) continues with poor appetite and suboptimal P.O. (by mouth) intakes .Weight loss is attributed to Res current illness/infection and decreased appetite .Diet order was liberalized to remove renal restriction .Summary of recommendation .d/c (discontinue) fluid restriction-not indicated at this time . The care plan dated April 19, 2024, indicated .Dialysis .Fluid restriction has been discontinued .Revision on 08/119/2024 .Intervention .Monitor intake and output . The care plan dated April 22, 2024, indicated, .Dehydration: At risk for dehydration or electrolyte imbalance . On hemodialysis .Goal .Will have evidence of adequate hydration .Provide additional fluids during activities if not contraindicated .Update fluid preferences as needed .Water pitcher within reach at bedside if not contraindicated . There was no documented evidence from the period of June 21, 2024 to August 22, 2024, Resident 23's fluid intake was monitored accurately and consistently through I&O's to ensure Resident 23 is not having complications from fluid imbalance such as fluid overload or dehydration related to dialysis treatment and dx of ESRD. On August 21, 2024, at 7:55 a.m., an interview with a concurrent record review was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 stated he was the licensed nurse assigned to Resident 23 and he was not sure if Resident 23 was on fluid restriction. LVN 1 stated the green dot sticker observed on Resident 23's name by the door indicated he was on a fluid restriction but it did not indicate in his medical record that he had a physician's order for it. LVN 1 further stated he did not know why Resident 23 did not have water pitcher by his bedside. On August 22, 2024, at 1:51 p.m., an observation with an interview and concurrent record review were conducted with LVN 2. LVN 2 stated Resident 23 had a physician's order for Intake and Output (I&O) monitoring every shift because of ESRD and he is a dialysis resident. LVN 2 stated the LN document in the electronic Administration Record (eMAR) the total amount of fluid intake every shift based on the fluid intake information the CNA's document in their tasks. LVN 2 stated she did not offer extra fluids on her shift when she was assigned to Resident 23. LVN 2 stated if a resident was on I&O monitoring, the LN should document the total amount of fluid intake per shift in the electronic Medication Administration Record (eMAR) , and an I&O monitoring form should be posted in Resident 23's room for the Certified Nursing Assistants (CNAs) to complete. LVN 2 went to Resident 23's room, and stated she did not see an I&O monitoring form posted. LVN 2 stated she did not know Resident 23 was taken off fluid restriction since June 21, 2024. LVN 2 stated the fluid restriction discontinued on June 21, 2024, was not communicated to the nurses. On August 23, 2024, at 9:39 a.m., an interview and concurrent record review were conducted with LVN 3. LVN 3 stated Resident 23 was a hemodialysis resident and had a physcian's order for I&O monitoring every shift. LVN 3 stated Resident 23 should be monitoried for I&O becuase he is a dialysis resident and is at high risk fluid overload. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 3 reviewed the I&O monitoring in the eMAR for Resident 23 from the period of June 2024 to August 21, 2024. LVN 3 stated the I&O monitoring entries were incomplete and did not indicate an accurate monitoring of Resident 23's fluid intake and output. In addition, LVN 3 stated there was no documentation Resident 23 was monitored for adequate fluid hydration since the fluid restriction was discontinued on June 21, 2024. LVN 3 stated from June 1, 2024, to August 21, 2024, the eMAR review showed Resident 23 was still on fluid restriction because the average total of fluid intake in 24 hours was less than 1500 milliliter. LVN 3 stated, because of the incomplete fluid intake information, it is difficult to verify if Resident 23 had suffcient fluid intake or if there was fluid overload since the fluid restriction was discontinued on June 21, 2024. LVN 3 stated if Resident 23 was not monitored accurately for I&O, the outcome on the resident may be either fluid overload or dehydration. LVN 3 stated the nurses did not follow the facility's policy and procedure on fluid intake monitoring. The facility's policy and procedure titled, Intake, Measuring and Recording, dated October 2010, was reviewed. The policy indicated, .Purpose .The purpose of this is to accurately determine the amount of liquid a resident consumes in a 24-hour period .Review the resident's care plan to assess for any special needs of the resident .Record the fluid intake as soon as possible after the resident has consumed the fluids .At the end of your shift total the amount of all liquids the resident consumed .Record all fluid intake on the intake and output record in cubic centimeter .Post an intake and output record form in the resident's room . Documentation . The following information should be recorded in the resident's medical record .The date and time the resident's fluid intake was measured and recorded .The name and title of the individual who measured and recorded the resident's fluid intake .The type of liquid consumed (i.e. tea, milk, coffee, soup, etc.) .If the resident refused the treatment, the reason (s) why and the interventions taken . The facility policy and procedure titled, Residents Hydration, dated October 2017, was reviewed. The policy indicated, .Nursing will monitor and document fluid intake and the dietician will be kept informed of status . The Interdisciplinary Team will update the care plan and docuemnt resident response to interventions until the team agrees that fluid intake and relating factors are resolved .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 49113 Based on observation, interview, and record review, the facility failed to provide evidence of accountability for narcotic (controlled drug that induces stupor, coma, or insensibility to pain) pain medications, for 20 of 20 residents (Residents 98, 3, 30, 16, 80, 280, 18, 83, 26, 34, 23, 120 , 88, 95, 76, 65, 58, 19, 278 and 99). This failure resulted in delays in identifying drug discrepancies and the possible diversion of controlled medications. Findings: 1. On August 22, 2024, Resident 58's ADMISSION RECORD, was reviewed. Resident 58 was admitted to the facility on [DATE], with diagnoses that included muscle wasting (reduced muscle strength), atrophy (declining/deteriorating of a body part or tissue), and polyneuropathy (disease affecting peripheral nerves [tiny wires that receives and sends messages between the body and the brain]). A review of Resident 58's physician's order dated July 15, 2024, indicated Oxycodone-Acetaminophen 5-325mg (milligrams) tablet to be given by mouth every six hours PRN for moderated or severe pain. A review of Resident 58's medication count sheet and August eMAR for Oxycodone/Acetaminophen 5-325mg for the period of August 2 to 17, 2024, indicated the licensed nurses signed out the Oxycodone-Acetaminophen 5-325mg and did not indicate that Oxycodone-Acetaminophen 5-325mg was administered to the resident on the following dates and times: -August 5, 2024, at 12:00 p.m. -August 5, 2024, at 8:00 p.m. -August 7, 2024, at 4:00 p.m. -August 10, 2024, at 2:00 p.m. -August 14, 2024, at 9:00 p.m. -August 17, 2024, at 8:30 a.m. On August 22, 2024, at 3:25 p.m., a concurrent interview and review of the narcotic count sheet and August electronic medication administration record (eMAR) for Resident 58 were conducted with Licensed Vocational Nurse LVN 7. LVN 7 stated the facility's process for giving PRN (as needed) narcotic pain medications required the licensed nurse to assess the patient, check the order, sign out the medication from the narcotic count sheet, enter the pain level in the eMAR, administer the medication, and follow up in an hour to reassess the resident. LVN 7 stated, Oxycodone-Acetaminophen 5-325mg was signed out by the licensed nurses from August 2 to 17, 2024. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a further interview, LVN 7 stated he signed out the Oxycodone-Acetaminophen 5-325mg on the medication count sheet but did not document in the eMAR after giving the medication. LVN 7 stated he should have documented that he administered the medication in the eMAR. 2. On August 22, 2024, Resident 65's ADMISSION RECORD, was reviewed. Resident 65 was admitted to the facility on [DATE], necrotizing fasciitis (bacterial infection of tissue under the skin) and polyneuropathy (disease affecting peripheral nerves[tiny wires that receives and sends messages between the body and the brain]). A review of Resident 65's physician's order, dated April 6, 2024, indicated, Oxycodone-Acetaminophen-10-325mg (milligrams) tablet to be given every six hours for pain management, and one tablet every four hours as needed for severe to very severe pain. A review of Resident 65's medication count sheet and August eMAR for Oxycodone/Acetaminophen 10-325mg from the period of August 3 to 20, 2024, indicated the licensed nurses signed out the Oxycodone-Acetaminophen 10-325mg from the medication count sheet and did not document that Oxycodone-Acetaminophen 10-325mg was administered to the resident on the following dates and times: August 17, 2024, at 3:00 p.m. August 17, 2024, at 6:00 p.m. August 17, 2024, at 9:00 p.m. On August 22, 2024, at 3:40 p.m., a concurrent interview and review of the narcotic medication reconciliation for Resident 65, were conducted with Licensed Vocational Nurse LVN 8. LVN 8 stated he signed out the Oxycodone-Acetaminophen 10-325mg from August 3 to 20, 2024 from the medication count sheet. LVN 8 stated he did not document the administration of the medication in Resident 65's eMAR. LVN 8 stated he should have documented the administration Resident 65's pain medication and stated it is important to document to make sure the resident is not double-dosed. 25281 3. On August 20, 2024, at 10 a.m., during the medication cart inspection in Nursing Station East, blister cards containing controlled substances (CS) stored in the 300 Hall Medication Cart were audited to determine the accuracy of CS accountability with LVN 1. The following discrepancies in the documentation of administration in Resident 19's medical record were noted: The resident's blister card for hydrocodone/acetaminophen 10/325 milligram (brand name: Norco 10, a narcotic pain medication) was labeled with the direction to give the resident one tablet by mouth every 12 hours for pain management; The Medication Count Sheet for the resident's Norco 10 indicated one dose was signed out by nursing staff on August 10, 11, 13, 14, 16, and 18; and (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The resident's electronic medication administration record (EMAR) indicated two doses were administered on August 10, 11, 13, 14, 16, and 18. During a concurrent interview, LVN 1 acknowledged missing documentation. 4. On August 20, 2024, at 10 a.m., during the medication cart inspection in Nursing Station East, blister cards containing controlled substances (CS) stored in the 300 Hall Medication Cart were audited to determine the accuracy of CS accountability with LVN 1. The following discrepancies in the documentation of administration in Resident 278's medical record were noted: The resident's blister card for oxycodone/acetaminophen 10/325 milligram (brand name: Percocet 10, narcotic pain medication) was labeled with the direction to give the resident one tablet by mouth every 4 hours as needed; The Medication Count Sheet for the resident's Percocet 10 indicated three doses were signed out by nursing staff on August 17 and on August 18; and The resident's EMAR indicated none was administered on August 17 and only two doses were administered on August 18. During an interview on August 22, 2024, at 10:59 a.m., LVN 1 stated he was not able to find documentation of administration in the residents' medical records. 50309 5. On August 21, 2024, Resident 23's ADMISSION RECORD, was reviewed. Resident 23 was admitted to the facility on [DATE], with diagnoses which included end-stage renal disease (ESRD - when the kidneys stop working) on hemodialysis (special procedure done by a trained professional to remove wastes and excess fluids from the body) and fracture (broken bone) on left fibula (long bone in the lower extremity) bone. A review of Resident 23's Order Summary Report, included a physician's order, dated May 6, 2024, indicated to give Tramadol HCL 1 tablet 50 mg by mouth every six hours as needed for moderate to severe pain. A review of Resident 23's Medication Count Sheet, for the month of August 2024, indicated eleven doses of Tramadol HCL 50 mg were signed out by the Licensed Nurse (LN) on the following dates and times: - August 2, 2024, at 9 p.m. - August 6, 2024, at (time illegible). - August 8, 2024, at 12 p.m. - August 8, 2024, at (time illegible). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- August 9, 2024, at 8:05 a.m., 6 p.m., and 9:30 p.m. - August 13, 2024, at (time illegible). - August 14, 2024, at 12 p.m. and 6 p.m. -August 15, 2024, at 10 a.m.; and - August 16, 2024, at 8:00 a.m. Further review of Resident 23's eMAR indicated there was no documentation that Tramadol was administered to Resident 23. On August 20, 2024, at 5:55 p.m., an interview and a concurrent review of Resident 23's August eMAR were conducted with LVN 12. LVN 12 stated the LN signed out the tramadol HCL 50 mg on August 2, 6, 8, 9, 13, 14, 15, and 16, 2024. LVN 12 stated there was no documentation in the eMAR, indicating the LN administered the pain medication to Resident 23. LVN 12 stated he was the LN who signed out Resident 23's Tramadol 50 mg on August 14, 2024, at 6:00 p.m. LVN 12 stated there was no documentation in Resident 23's August eMAR that he administered the medication. 6. On August 21, 2024, Resident 26's ADMISSION RECORD,was reviewed. Resident 26 was admitted to the facility on [DATE], with diagnoses which included chronic pain syndrome (persistent pain that lasts weeks to years) and lower back pain. A review of Resident 26's Order Summary Report, included a physician's order, dated May 6, 2024, which indicated to give Tramadol HCL 1 tablet 50 mg by mouth every six hours as needed for moderate to severe pain. A review of Resident 26's Medication Count Sheet, for the month of July 2024, indicated two doses of Tramadol were signed out by the LN on the following dates and times: - July 10, 2024, at 5 p.m.; and - July 27, 2024, at 5 p.m. Further review of Resident 26's July eMAR indicated there was no documentation that the LN administered the two doses of Tramadol signed out by the LN. On August 21, 2024, at 4:38 p.m., an interview and a concurrent review of Resident 26's narcotic medication reconciliation were conducted with Licensed Vocational Nurse (LVN) 9. LVN 9 stated the facility's process in giving PRN (as needed) narcotic pain medications was for the licensed nurse to sign out the medication from the narcotic count sheet, administer the medication to the resident, document and sign the date and time the medication was administered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During furthe interview, LVN 9 stated Resident 26's eMAR on July 10 and 27, 2024, did not indicate the LN administered the two doses of Tramadol 50 mg to Resident 26, after being signed out from the medication count sheet. LVN 9 further stated he was the LN who signed out Resident 26's Tramadol 50 mg on July 10, 2024, at 5:00 p. m. LVN 9 stated he did not document in Resident 26's eMAR that he administered the medication to Resident 26 and that he should have documented it. 7. On August 21, 2024, Resident 34's record was reviewed. Resident 34 was admitted to the facility on [DATE], with diagnoses that included contusion (bruise caused by bleeding under the skin due to an injury) of the head and osteoarthritis (bone pain). A review of Resident 34's Order Summary Report, included a physician's order, dated May 31, 2024, which indicated the following: - hydrocodone-acetaminophen 10-325 mg 1 tablet every 4 hours for severe to very severe pain; and - hydrocodone-acetaminophen 5-325 mg every 4 hours as needed for moderate pain. A review of Resident 34's Medication Count Sheet, for the month of August 2024, indicated ten doses of hydrocodone-acetaminophen 10-325 mg were signed out by the Licensed Nurse (LN) on the following dates: - August 15, 2024, at 4 a.m. - August 15, 2024, at 3 p.m. - August 15, 2024, at 7 p.m. - August 16, 2024, at 11 a.m. - August 16, 2024, at 3 p.m. - August 16, 2024, at 7 p.m. - August 16, 2024, at 11 p.m. - August 17, 2024, at 8 a.m. - August 17, 2024, at 3:30 p.m.; and - August 20, 2024, at 4:15 a.m. A review of Resident 34's Medication Count Sheet, for the month of August 2024, indicated nine doses of hydrocodone-acetaminophen 5-325 mg 1 tablet was signed out by the Licensed Nurse (LN) on the following dates: - August 15, 2024, at 8 a.m. - August 15, 2024, at 12 p.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- August 16, 2024, at 2 p.m. - August 17, 2024, at 4:10 a.m. - August 17, 2024, 11:30 a.m. - August 17, 2024, at 5:30 p.m. - August 18, 2024, at 6:30 p.m. - August 19, 2024, at 3:50 a.m.; and - August 19, 2024, at 9 p.m. Further review of Resident 34's August eMAR indicated there was no documenation that the LN administered the hydrocodone-acetaminophen 10-325 mg and 5-325 mg to Resident 34. On August 21, 2024, at 10:38 a.m., a concurrent interview and review of Resident 34's narcotic medication reconciliation were conducted with Licensed Vocational Nurse (LVN) 12. LVN 12 stated the facility's process for giving PRN (as needed) narcotic pain medications required the licensed nurse to sign out the medication from the narcotic count sheet, administer the medication to the resident, document in the resident's electronic Medication Administration Record (eMAR), and sign the date and time the medication was administered. LVN 12 stated Resident 34's eMAR for August 15-20, 2024, did not indicate that the licensed nurse administered the medication Hydrocodone-Acetaminophen 10-325 mg and Hydrocodone-Acetaminophen 5-325 mg to Resident 34, after the medications were signed out. LVN 12 stated the licensed nurses should have documented and signed in Resident 34's eMAR the date and time the medication was administered. 8. On August 21, 2024, Resident 83's ADMISSION RECORD, was reviewed. Resident 83 was admitted to the facility on [DATE], with diagnoses which included neuralgia (pain caused by damaged nerves), chronic pain, and muscle weakness. A review of Resident 83's Order Summary Report, included a physician's order, dated August 20, 2022, which indicated to give hydrocodone-acetaminophen 10-325 mg 1 tablet by mouth every 4 hours as needed for severe to very severe pain. A review of Resident 83's Medication Count Sheet, for the month of July 2024 and August 2024, indicated 11 doses of hydrocodone-acetaminophen 10-325 mg were signed out by the Licensed Nurses on the following dates: - July 3, 2024, at 10 p.m. - July 6, 2024, at 11 p.m. - July 9, 2024, at 12 a.m. - July 17, 2024, at 7 p.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- July 20, 2024, at 8 p.m. - July 22, 2024, at 9 p.m. - July 24, 2024, at 6 p.m. - August 5, 2024, at 7 p.m. - August 7, 2024, 9 p.m. - August 11, 2024, 9 a.m.; and - August 14, 2024, at 8 p.m. Further review of Resident 83's July and August eMAR indicated there was no documentation that the 13 doses of Hydrocodone-Acetaminophen 10-325 mg were administered to Resident 83. On August 21, 2024, at 10:42 a.m., a concurrent interview and review of Resident 83's narcotic medication reconciliation were conducted with Licensed Vocational Nurse (LVN) 2. LVN 2 stated the facility's process in giving PRN (as needed) narcotic pain medications required the licensed nurse to sign out the medication from the narcotic count sheet, administer the medication to the resident, document in the resident's eMAR, sign the date and time the medication was administered. LVN 2 stated Resident 83's eMAR from July 3, 2024, to August 24,2024 did not indicate the licensed nurses documented the Hydrocodone-Acetaminophen 10-325 mg medication was administered to Resident 83. LVN 2 further stated the licensed nurses should have documented and signed in Resident 83's eMAR, the date and time the medication was administered to Resident 83. 9. On August 21, 2024, Resident 99's ADMISSION RECORD, was reviewed. Resident 99 was admitted to the facility on [DATE], with diagnoses which included osteoarthritis (bone pain), pain in right hip, chronic pain syndrome, muscle spasm (muscle cramps), and neuralgia (pain caused by damaged nerves). A review of Resident 99's Order Summary Report, included a physician's order, dated May 16, 2024, indicated to give 1 tablet hydrocodone-acetaminophen 10-325 mg give 1 tablet by mouth every 6 hours for severe to very severe pain. A review of Resident 99's Medication Count Sheet, for the month of August 2024, indicated eight doses of hydrocodone-acetaminophen 10-325 mg were signed out by the LN on the following dates: - August 16, 2024, at 8 a.m. - August 16, 2024, at 9 p.m. - August 17, 2024, at 8:22 a.m. - August 17, 2024, at 6 p.m. - August 18, 2024, at 9 p.m. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sundance Creek Post Acute	5800 West Wilson Street Banning, CA 92220

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- August 19, 2024, at 3:40 p.m. - August 19, 2024, at 11 p. m.; and - August 20, 2024, at 9 p.m. Further review of Resident 99's August eMAR indicated there was no documentation that the 13 doses of Hydrocodone-Acetaminophen 10-325 mg were administered to Resident 99. On August 21, 2024, at 10:03 a.m., a concurrent interview and review of Resident 99's narcotic medication reconciliation were conducted with Licensed Vocational Nurse (LVN) 2. LVN 2 stated the facility's process in giving PRN (as needed) narcotic pain medications required the licensed nurses to sign out the medication from the narcotic count sheet, administer the medication to the resident, document in the resident's eMAR and sign the date and time the medication was administered. LVN 2 stated Resident 99's eMAR from August 16-20, 2024, did not indicate the licensed nurses documented the Hydrocodone-Acetaminophen 10-325 mg as administered to Resident 99. LVN 2 further stated the licensed nurses should have documented and signed in Resident 99's eMAR, the date and time the medication was administered. 10. On August 21, 2024, Resident 120's record was reviewed. Resident 120 was admitted to the facility on [DATE], with diagnoses including intervertebral disc degeneration (damaged flat, round cushions located between each vertebra in the spine causing pain), surgical aftercare following a craniotomy (surgery of the brain). A review of Resident 120's Order Summary Report, included the following physician's order: - Oxycodone HCL (narcotic pain medication) 5 MG 1 tablet by mouth every 4 (four) hours for moderate pain . date ordered July 10, 2024; and -Oxycodone 10 MG Give 1 (one) tablet by mouth every 4 (four) hours as needed for severe pain ., date ordered July 10, 2024. A review of Resident 120's Medication Count Sheet, for the month of July 2024, indicated 14 doses of Oxycodone HCL 10 mg were signed out by the LN on the following dates and times: - July 11, 2024, at 12 p.m. - July 11, 2024, at 5:30 p.m. - July 11, 2024, at 10 p.m. - July 13, 2024, at 4:30 p.m. - July 13, 2024, 9 p.m. - July 14, 2024, at 4 a.m. - July 14, 2024, at 10 p.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- July 15, 2024, at 9 a.m. -July 16, 2024, at 9 a.m. - July 16, 2024, at 1 p.m. - July 17, 2024, at 4:30 a.m. - July 18, 2024, at 4:30 p.m. - July 21, 2024, at 9 p.m.; and - August 2, 2024, at 9 p.m. A review of Resident 120's Medication Count Sheet, indicated Oxycodone HCL 5 mg was signed out by the LN on the following dates and times: - July 13, 2024, at 1:08 a.m. - July 14, 2024, at 8:12 a.m. - July 14, 2024, at 12 p.m.; and - July 14, 2024, at 5 p.m. Further review of Resident 120's July and August eMAR indicated there was no documentation that the 13 doses of Oxycodone HCL 10 mg and 4 doses of Oxycodone HCL 5mg were administered to Resident 120. On August 21, 2024, at 10:15 a.m., a narcotic medication reconciliation for Resident 120 as conducted with Licensed Vocational Nurse (LVN) 2. LVN 2 stated the facility's process in giving PRN (as needed) narcotic pain medications was for the licensed nurse to sign out the medication from the narcotic count sheet, administer the medication to the resident, document in the resident's eMAR and sign the date and time the medication was administered. LVN 2 stated Resident 120's eMAR from July 11-21, 2024, and August 2, 2024, did not indicate the licensed nurses documented the Oxycodone HCL 10 mg and 5 mg as administered to Resident 120. LVN 2 further stated the licensed nurses should have documented and signed in Resident 120's eMAR, the dates and time the medication were administered to Resident 120. During further interview, LVN 2 stated she was the licensesd nurse who signed out Resident 120's Oxycodone HCL 10mg medication count sheet on July 11 (12:00 p.m., 5:30 p.m., and 10:00 p.m.), July 16 (1:00 p.m.), July 18 (4:30 p.m.), 2024, and Resident 120's Oxycodone HCL 5mg medication count sheet on July 14 (8:12 a.m., 12:00 p.m. and 5:00p.m.), 2024. LVN 2 stated she did not sign and document on the eMAR the dates and time the Oxycodone HCL was administered. LVN 2 further stated she did not follow the facility's process on administration of PRN pain medications. LVN 2 stated without documentation, there was a potential for medication errors to occur. 50204 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	11. On August 20, 2024, Resident 18's ADMISSION RECORD, was reviewed. Resident 18 was admitted to the facility on [DATE], with diagnoses which included osteomyelitis of vertebra (swelling of the bone or back bone), and diverticulosis of large intestine (small pouches in the wall of intestines). A review of Resident 18's Order Summary Report, included a physician's order, dated May 17, 2024, indicated, Tramadol HCL (hydrochloride) Tablet (narcotic pain medication) 50 MG (milligram) .Give 1 (one) tablet by mouth every 6 (six) hours as needed for Pain Moderate to severe pain . A review of Resident 18's Medication Count Sheet, for the month of August 2024, indicated that seven doses of Tramadol were signed out by the licensed nurse on the following dates and time: - August 4, 2024, at 8 p.m. -August 5, 2024, at 5:10 p.m. -August 6, 2024, at 9 a.m. -August 8, 2024, at 5 p.m. -August 9, 2024, at 6 p.m. -August 11, 2024, at 9 p.m.; and -August 15, 2024, at 2 p.m. Further review of Resident 18's August eMAR indicated there was no documentation in the eMAR that the seven doses of Tramadol were administered to Resident 18. On August 20, 2024, at 5:08 p.m., a concurrent interview and review of Resident 18's narcotic medication reconciliation were conducted with Licensed Vocational Nurse (LVN) 3. LVN 3 stated the facility's process in giving PRN (as needed) narcotic pain medications required the licensed nurse to sign out the medication from the medication count sheet, administer the medication to the resident, document in the resident's eMAR and sign the date and time the medication was administered. LVN 3 stated Resident 18's eMAR from August 1 to 21, 2024, did not indicate the licensed nurses administered the medication Tramadol to Resident 18, after the medication was signed out from the medication count sheet. LVN 3 further stated should have documented and signed in Resident 18's MAR, the date and time the medication was administered. On August 21, 2024, at 10:15 a.m., an interview and concurrent review of Resident 18 August eMAR were conducted with LVN 9. LVN 9 stated he was the licensed nurse who signed out the Tramadol on August 11, 2024, at 9:00 p.m., but did not sign and document on the eMAR the date and time the Tramadol was administered to Resident 18. LVN 9 further stated he should have signed and documented on the eMAR. On August 21, 2024, at 10:15 a.m., an interview was conducted with LVN 1. LVN 1 stated he was the licensed nursed who signed out Resident 18's Tramadol 50 mg on August 6 and 8, 2024. LVN 1 stated he did not sign and document on the eMAR the date and time the Tramadol was administered. LVN 1 further stated he missed signing, and he, forgot at that time to document in Resident 18's eMAR. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	47202 12. On August 21, 2024, Resident 98's record was reviewed. Resident 98 was admitted to the facility on [DATE] with diagnoses which included Arthritis (swelling or tenderness of the joints). A review of Resident 98's Order Summary Report, dated August 20, 2024, indicated, .Tramadol HCL Oral Tablet (a narcotic) 50 mg (milligrams - unit of measurement) give 1 (one) tablet by mouth every 12 hours as needed for right side pain . A review of Resident 98's Medication Count Sheet, dated June through July 2024, indicated seven doses of Tramadol HCL 50 mg tablet were signed out on the following dates and times: - June 24, 2024 at 5:00 p.m. - July 5, 2024 at 5:00 p.m. - July 12, 2024 at 9:00 p.m. - July 15, 2024 at 6:00 p.m. - July 16, 2024 at 6:00 p.m. - July 17, 2024 at 6:00 p.m., and - July 19, 2024 at 4:00 p.m. A review of Resident 98's Electronic Medication Administration Record (eMAR), dated June through July 2024, did not indicate Tramadol was administered to Resident 98. There was no documented evidence Tramadol was administered to Resident 98. On August 21, 2024, at 9:56 a.m., during a concurrent interview and review of Resident 98's June and July eMAR with LVN 4, she stated the process for pain medication administration is when a resident asked for pain medication, the pain level and location is assessed, the pain medication is signed out on the narcotic count sheet and the medication is administered to the resident. LVN 4 further stated the medication administration is documented in the eMAR to indicate the medication was administered to the resident. During further interview, LVN 4 stated Residents 98 narcotic pain medications should have been documented in the eMAR to indicate the medication was administered to the residents and prevent medication errors that could lead to overdose and or harm to the resident. 13. On August 21, 2024, Resident 30's record was reviewed. Resident 30 was admitted to the facility on [DATE], with diagnoses which included malignant neoplasm of the pancreas (a type of cancer). A review of Resident 30's Order Summary Report, dated August 20, 2024, indicated, .Norco (a narcotic) Oral Tablet 5-325 mg (Hydrocodone-Acetaminophen - generic name for Norco) give 1 tablet by mouth every 6 hours as needed for severe to very severe pain . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of Resident 30's Medication Count Sheet, dated March through May 2024, indicated six doses of hydrocodone-acetaminophen 5-325 mg were signed out on the following dates and times: - March 24, 2024 at 7:00 a.m. - May 22, 2024 at 9:00 p.m. - May 23, 2024 at 9:00 p.m. - May 27, 2024 at 9:00 p.m. - May 28, 2024 at 9:00 p.m., and - May 22, 2024 at 6:00 p.m. A review of Resident 30's eMAR dated March through May 2024, did not indicate Norco was administered to Resident 30. There was no documented evidence Norco was administered to Resident 30 in the medical record. On August 21, 2024, at 9:56 a.m., LVN 4 stated Resident 30's narcotic pain medications should have been documented in the eMAR to indicate the medication was administered to the residents and to prevent medication errors that could lead to overdose or harm. On August 22, 2024 at 11:33 a.m., during an interview with LVN 5, she stated she was the person who signed out Resident 30's Norco and she did not document the medication administration in the resident's eMAR. LVN 5 stated she should have documented the administration of the medication to prevent medication errors and duplicate doses that could harm the residents. 14. On August 21, 2024, Resident 3's record was reviewed. Resident 3 was admitted to the facility on [DATE]. A review of Resident 3's Minimum Data Set (an assessment tool), dated June 26, 2024, indicated, Resident 3 had a BIMS (Brief Interview of Mental Status) Score of 11 (moderate cognitive impairment). A review of Resident 3's Order Summary Report, dated August 20, 2024, indicated, .Norco Tablet 10-325 MG (Hydrocodone-Acetaminophen) give 1 (one) tablet by mouth every 6 (six) hours as needed for severe to very severe pain . A review of Resident 3's Medication Count Sheet, dated July through August 2024, indicated Hydrocodone-Acetamin (sic) (Acetaminophen) 10-325 mg was signed out on the following dates: - July 31, 2024 at 8:00 a.m. - August 1, 2024 at 11:00 p.m. - August 2, 2024 at 9:00 p.m. - August 4, 2024 at 7:00 a.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- August 8, 2024 at 10:00 a.m., and - August 9, 2024 at 9:00 a.m. A review of Resident 3's MAR, dated July through August 2024, did not indicate Norco was administered to Resident 3. There was no documented evidence Norco was administered to Resident 3 in the medical record. On August 20, 2024, at 4 p.m., LVN 6 was interviewed. LVN 6 stated she was one of the nurses who signed out Resident 3's Norco and she did not document the medication administration in the resident's MAR. LVN 6 stated she should have documented in the eMAR to prevent duplicate medication administration that could lead to overdose and harm the resident. 44270 15. A review of Resident 16's record indicated Resident 16 was admitted to the facility on [DATE], with diagnosis which included muscle wasting and atrophy (weak muscles). Further review of Resident 16's facility document titled, Order Summary Report, indicated the following orders dated December 20, 2022 and July 27, 2024: -TraMADol HCl Tablet 50 mg Give 1 tablet by mouth every 24 hours as needed for Very Severe Pain (9-10) Additional review of Resident 16's August electronic Medication Administration Record (eMAR) indicated Resident 16 was administered Tramadol HCL during the following dates and times: -August 12, 2024, at 6:00 a.m. -August 13, 2024, at 6:00 a.m. -August 15, 2024, at 6:00 a.m. On August 22, 2024, at 11:17 a.m., a concurrent review of Resident 16's August eMAR and interview were conducted with LVN 1. LVN 1 stated there was no documentation in Resident 16's August eMAR indicating Tramadol HCL medication was administered to Res 16 on August 12, 13, and 15, 2024. LVN 1 stated the licensed nurses should have documented in the August 2024 eMAR if these medications were administered. On August 22, 2024 at 11:33 a.m. an interview was conducted with LVN 5. LVN 5 stated she was familiar with Resident 16 and that on August 12, 13, and 15, 2024, she signed out Resident 16's pain medication. LVN 5 stated she did not document in the eMAR she administered the medication to the resident. LVN 5 stated she should have documented, she administered the medication. 16. A review of Resident 80's record indicated Resident 80 was admitted to the facility on [DATE], with diagnosis which included pain in left lower leg, pain in the right lower leg, and other chronic pain (long lasting pain). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Further review of Resident 80's facility document titled, Order Summary Report, indicated the following orders dated May 16, 2024, and July 9, 2022: -Morphine Sulfate IR Oral Tablet 30 mg (Morphine Sulfate) Give 30 mg by mouth every 8 hours as needed for Breakthrough Pain Do not give with NORCO at same time (AT LEAST 1 HR INTERVAL) . -Norco Tablet 10-325 mg (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 6 hours for Pain Management . Additional review of Resident 80's eMAR dated August 13, 14, 16, and 19, 2024, indicated Resident 80 was administered Morphine HCL, signed by staff during the following dates and times: -August 13, 2024, at 11:00 a.m. -August 13, 2024, at 7:00 p.m. -August 14, 2024, at 3:00 a.m. -August 14, 2024, at 11:00 a.m. -August 14, 2024, at 7:00 p.m. -August 16, 2024, at 3:00 a.m. -August 16, 2024, at 11:00 a.m. -August 16, 2024, at 7:00 p.m. -August 19, 2024, at 3:00 a.m. -August 19, 2024, at 11:00 a.m. -August 19, 2024, at 7:00 p.m. On August 22, 2024, at 10:12 a.m. a concurrent interview and review of Resident 80's August eMAR were conducted with the Licensed Vocational Nurse (LVN) 10. LVN 10 stated pain medication administration should then be documented in the eMAR, the medication would then be prepared and signed out from the count sheet with time and initials, then provide the medication to the resident. LVN 10 stated for August 13, 2024, he administered Morphine Sulfate to Resident 80 and that he did not document he administered the medication. On August 22, 2024, at 10:58 a.m. a concurrent interview and review of Resident 80's August eMAR were conducted with LVN 11. LVN 11 stated she administered Morphine Sulfate HCL to Resident 80 on August 19, 2204. LVN 11 stated she did not document in the MAR she administered the medication to the resident. On August 22, 2024, at 11:33 a.m. an interview was conducted with

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49113 Based on interview and record review, the facility failed to ensure behavior monitoring was conducted for the use of Olanzapine (used to treat schizophrenia - a condition that affects a person's ability to think, feel. and behave clearly), for one of five residents reviewed for unnecessary medication (Resident 278). This failure to identify and monitor specific behavior manifested had the potential to put Resident 278 at risk of receiving unnecessary medication, which could result in serious harm. Findings: On August 23, 2024, Resident 278's medical record was reviewed. Resident 278 was admitted to the facility on [DATE], with diagnoses which included schizophrenia. On August 23, 2024, a review of Resident 278's Minimum Data Set (MDS - an assessment tool) was reviewed. Resident 278's MDS indicated under Section C, Resident 278's Brief Interview for Mental Status (a screening tool used to assess the mental state of residents) Score was 11 (cognition moderately impaired). On August 23, 2024, a review of Resident 278's physician order dated July 7, 2024, indicated, OLANzapine Oral Tablet 15 MG (milligram) by mouth .M/B (manifested by) Auditory Hallucinations . Further review of Resident 278's medical record indicated that there was no documentation of monitoring for Resident 278's behavior for auditory hallucinations. On August 23, 2024, at 11:27 a.m. a concurrent interview and record review with the Director of Nursing,(DON), were conducted. The DON was unable to provide documentation of behavior monitoring for Resident 278's auditory hallucination in the Electronic Medical Record (eMAR-software that helps manage patients' medication information). The DON stated, Resident 278 did not have a care plan addressing resident's auditory hallucination behavior. The DON stated, having a care plan in place is important because it ensures that everyone knows how to handle the resident, knows what the resident's goals are, and helps manage the resident's behavior. On August 23, 2024, at 2:08 p.m. an interview and record review with MDS were conducted. The MDS stated Resident 278 was admitted on [DATE], with a medication order for Olanzapine but a care plan for behavior monitoring on auditory hallucinations was not created at admission. The MDS stated the licensed nurses should be monitoring Resident 278's behavior regarding auditory halluciantions. The MDS stated monitoring resident's behavior would provide a basis for gradual dose reduction and, if behavior does not improve, a review by the doctor for possible adjustment. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy and procedure titled, Psychoactive/Psychotropic Medication Use undated was reviewed. The policy indicated, .Monitoring of a resident receiving Psychotropic medication will include evaluation of the effectiveness of the medication, as well as an assessment for the possible adverse consequences. Behavioral symptoms are reevaluated periodically to determine the potential for reducing or discontinuing the drug based on therapeutic goals, and any adverse effects or possible functional impairment . The facility's policy and procedure titled, Care Planning - Interdisciplinary Team, dated September 2013 was reviewed. The policy indicated, .Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan . The care plan is based on the resident's comprehensive assessment and is developed by a Care Planning/Interdisciplinary Team . The facility's policy and procedure titled, Admission Assessment, dated September 2012, was reviewed. The policy indicated, .The purpose of this procedure is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan, and completing required assessment instruments, including the MDS .

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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** 49113 Based on observation, interview, and record review, the facility failed to ensure discontinued medications were stored properly and not readily available for use when two vials/bottles of Lorazepam (used to treat anxiety [feeling of fear]) and Insulin Lispro Injection (a rapid-acting insulin used to lower blood sugar level) were observed in the medication room refrigerator. This failure had the potential to result in the accidental administration of discontinued medication to residents. Findings: On [DATE], at 2:30 p.m., during a concurrent observation, interview, and record review with Registered Nurse (RN) 2 in the Westside medication room, two bottles/vials of lorazepam, one insulin (Humalog) lispro injection pen with d/c (discontinued) written on it were observed. RN 2 stated the facility's process for discontinued medication is to give the medicine to the resident at discharge or destroy the medication. RN 2 stated the medications should not be left in the refrigerator and was not sure why they were still in the refrigerator. RN 2 stated the night shift nurses should have discarded the medication. On [DATE], at 4:48 p.m. an interview with the Director of Nursing (DON) was conducted. The DON stated that discontinued medication should not be kept in the refrigerator. The DON stated once a medication is discontinued, there is no need to keep it in the refrigerator. The DON stated discontinued medication should be placed in the discontinue bin. The DON stated narcotic medication should be destroyed with two nurse signatures. The DON stated that she and the pharmacist consultant destroy medications once a month. The facility's policy and procedures titled, Drug Disposition, undated, indicated, .Drugs discontinued by a physician's order and outdated drugs that cannot be returned to the pharmacy for credit, . are to be properly marked and disposed of in accordance with California's Medical Wase Management Act, the policy further states, .Discontinued or outdated non-controlled drugs are to be stored in a secured area designated for that purpose until picked up by the pharmaceutical disposal service or the pharmacy personnel. The facility's policy and procedures titled, Storage of Medication, dated [DATE], indicated .The facility shall not use discontinued, expired, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. The facility's policy and procedures titled, Discarding and Destroying Medications, dated [DATE], indicated, . medications refused by the resident, and/or medications left by residents upon discharge are disposed of in accordance with federal, state, and local regulations .

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 44504 Based on observations, interviews, and record reviews the facility failed to ensure Food and Nutrition Service employees were able to carry out their functions safely and effectively when: 1. Several Food and Nutrition Service employees were unable to properly clean used kitchen equipment; This failure had the potential to cause foodborne illness for 128 out of 129 sampled residents who received foods from the kitchen. 2. Two Diet Aide did not know the correct concentration of chlorine (sanitizer) for the dish machine. This failure had the potential to cause a strong chloride odor leading to cross-contamination of clean kitchenware for 128 out of 129 sampled residents who received foods from the kitchen. 3. [NAME] 1 did not follow the recipe for making pureed Bread Stuffing for lunch on 8/20/24; (Cross referred F 804) This failure resulted in eight out of eight residents receiving overly salty pureed Bread Stuffing, which may lead to decreased meal intake. Findings: 1. During a review of the facility's Policy and Procedure (P&P) titled, SHELVES, COUNTERS, AND OTHER SURFACES INCLUDING SINKS (HANDWASHING, FOOD PREPARATION, ETC.), dated 2023, the P&P indicated, CLEANING PROCEDURE: 1. Remove any large debris and wash surface with a warm detergent solution . 2. Rinse with clear water using a clean sponge or cloth. Wipe dry with a clean cloth. 3. Spray with a sanitizer. On August 19, 2024, at 9:19 a.m., a concurrent observation and interview were conducted with Diet Aide 1 (DA). DA 1 was observed cleaning a dirty meal cart. DA 1 stated she used detergent to clean the cart before sanitizing it. dirty meal cart and then sanitized the meal cart. On August 20, 2024, at 10:30 a.m., an interview was conducted with [NAME] 1 (CK). CK 1 was asked to demonstrate how she cleaned the used dirty blender base. CK 1 stated she only used sanitizer to clean the dirty blender base. On August 20, 2024, at 11:18 a.m., an interview was conducted with DA 2. DA 2 was asked to demonstrate how she cleaned the used stationary mixer. DA 2 stated she only used sanitizer for cleaning the stationary mixer. (continued on next page)

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Sundance Creek Post Acute	5800 West Wilson Street Banning, CA 92220

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On August 20, 2024, at 11:30 a.m., an interview was conducted with CK 2. CK 2 was asked to demonstrate how he cleaned the used stationary mixer. CK 2 stated he only used sanitizer for cleaning the stationary mixer. On August 21, 2024, at 9:19 a.m., an interview was conducted with the Registered Dietitian (RD) and Dietary Service Supervisor (DSS). The RD and DSS were asked to demonstrate the proper steps for cleaning used kitchen equipment. The DSS stated first step is to clean with detergent followed by sanitizing with sanitizer. The RD stated, the proper steps are: first removal of physical debris; second, wash with detergent; third, rinse with water, and lastly, sanitize with sanitizer. The RD acknowledged the used kitchen equipment were not cleaned properly if the procedure was not followed. The RD stated her expectation was for Food and Nutrition Service employees to follow facility's P&P cleaning procedure when cleaning kitchen equipment. During a review of the facility's Policy and Procedure (P&P) titled, DEMOSTRATRATING FOOD SAFETY AND JOB COMPENTENCY FOR FOOD AND NUTRITION SERVICES EMPLOYEES, dated 2023, the P&P indicated, POLICY: Each Food and Nutrition Services employee must be able to demonstrate competency in the food safety principles and job skills the facility requires. 2. On August 20, 2024, at 9:16 a.m., a concurrent observation and interview were conducted with DA 3. DA 3 was observed checking the chlorine of the dish machine and the chlorine test strip read level between 50-100 parts per million (ppm - a unit of measurement). DA 3 stated the test strip should read 200 ppm. On August 20, 2024, at 9:20 a.m., a concurrent observation and interview were conducted with DA 4 and the DSS. DA 4 was observed checking the chlorine level of the dish machine. DA 4 stated the test strip should read 200 ppm. The DSS stated the corrrect chlorine level for the dish machine test strip should be between 50-100 ppm, not 200 ppm. The DSS explained the 200 ppm indicated the concentration of the chlorine in dish machine was too high, which could result in a strong chloride odor being transferred to the clean kitchenware. During a review of the facility's Policy and Procedure (P&P) titled, DISHWASHING, dated 2023, the P&P indicated, .Low-temperature machine: .The chlorine should read 50 -100 ppm on dish surface in final rinse. During a review of the facility's Policy and Procedure (P&P) titled, DEMOSTRATRATING FOOD SAFETY AND JOB COMPENTENCY FOR FOOD AND NUTRITION SERVICES EMPLOYEES, dated 2023, the P&P indicated, POLICY: Each Food and Nutrition Services employee must be able to demonstrate competency in the food safety principles and job skills the facility requires. 3. On August 20, 2024, at 10:27 a.m., a concurrent observation and interview were conducted with CK 1. CK 1 was observed preparing pureed Bread Stuffing. CK 1 scooped out 12 servings of Bread Stuffing and adding 3 cups of chicken broth into blender; then blended them together to make pureed Bread Stuffing. CK 1 did not sample the pureed Bread Stuffing. A review of the facility document titled, RECIPE: PUREED BREADS, .AND OTHER BREAD PRODUCTS, undated, indicated, DIRECTIONS: .2. Puree on low speed adding milk . (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On August 20, 2024, at 12:14 p.m., a concurrent interview and a test meal (to evaluate the quality of a meal during a meal service and identify any areas for improvement) were performed for food palatability (refers to the taste and/or flavor of the food) of the puree diet meals were conducted with the RD in the East activities room. The surveyor tasted the pureed Bread Stuffing which was very salty. The RD stated CK 1 should have followed the recipe by adding milk instead of chicken broth. The RD explained the pureed Bread Stuffing was very salty because CK 1 two high salt content ingredients (chicken broth and bread stuffing). During a review of the facility document titled, The Facility's Resident Diet List, dated August 19, 2024, indicated eight residents, Residents 9, 11, 13, 15, 39, 50, 98 and 114 were on a pureed diet. During a review of the facility's Policy and Procedure (P&P) titled, FOOD PREPARATION, dated 2023, the P&P indicated, POLICY: Food shall be prepared by method that conserve nutritive value, flavor, and appearance. PROCEDURE: .2. Recipes are specific as .method of preparation .3. Prepared food will be sampled. The food and Nutrition Service employee who prepares the food will sample it to be sure the food has a satisfactory flavor .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44504 Based on observation, interview, and record review, the facility failed to follow its policy on MEAL SERVICE to provide appetizing food at appropriate temperatures according to residents' preferences for nine of 128 sampled residents (Resident 23, 26, 34, 35, 57, 62, 78, 97 and 426). This failure placed residents at potential risk to decrease nutritional intake and affect the resident's nutrition status. Findings: On August 19, 2024, at 9:41 a.m., an interview was conducted with Resident 35. Resident 35 stated, Food is cold during breakfast, lunch and dinner. On August 19, 2024, at 10:13 a.m., an interview was conducted with Resident 26. Resident 26 stated, Vegetables tasted old and no flavor; meat is tough, and they put too much dressing on salad. On August 19, 2024, at 10:47 a.m., an interview was conducted with Resident 97. Resident 97 stated, Food taste bad and is not good. On August 19, 2024, at 10:57 a.m., an interview was conducted with Resident 426's family. Resident 426's family stated provided foods did not taste good and her mom usually did not eat the provided foods. On August 19, 2024, at 11:36 a.m., an interview was conducted with Resident 62. Resident 62 stated, Food taste bad and the eggs are too runny when they served for breakfast. On August 19, 2024, at 12:05 p.m., an interview was conducted with Resident 23. Resident 23 stated, Food is cold, and flavor is not good. On August 19, 2024, at 12:15 p.m., an interview was conducted with Resident 426. Resident 426 stated, Meat is tough hard to chew. On August 19, 2024, at 12:20 p.m., an interview was conducted with Resident 34. Resident 34 stated, Food was bland, and the meat was tasteless and tough. I wish they served fresh veggies. Current served veggie look like leftovers and reheated. On August 19, 2024, at 2:43 p.m., an interview was conducted with Resident 78. Resident 78 stated, Food taste really bad. On August 20, 2024, at 9:23 a.m., an interview was conducted with Resident 57. Resident 57 stated, Milk is warm when it comes to me in the afternoon and evening. On August 20, 2024, at 11:50 a.m., a meal cart with test meal (to evaluate the quality of a meal during a meal service and identify any areas for improvement) inside was observation leaving the kitchen and parked outside the kitchen. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On August 20, 2024, at 11:55 a.m., an observation was conducted with the RD and DSS. Meal cart with test meal inside send to East hall way parked outside room [ROOM NUMBER]. Licensed Vocational Nurse (LVN) 4 checked each meal tray inside the meal cart. After LVN 4 completed checked the meal trays, CNAs took out some meal trays from meal cart and send them to residents without closing meal cart door. On August 20, 2024, at 12:02 p.m., an observation was conducted. Meal cart with test meal inside continue travelled down the hall and parked outside room [ROOM NUMBER]. CNAs took out some meal trays from meal cart and send them to residents without closing meal cart door. On August 20, 2024, at 12:08 p.m., an observation was conducted. Meal cart with test meal inside continue travelled down the hall and parked outside room [ROOM NUMBER]. CNAs took out some meal trays from meal cart and send them to residents. Last meal tray with feeding assistance was served at 12:14 p.m. On August 20, 2024, at 12:15 p.m., a concurrent interview and test meal was performed for food temperature and palatability (refers to the taste and/or flavor of the food) of the Renal and puree diet meals were conducted with the RD and DSS at East activity room. The following temperatures were obtained from the test meal: Renal diet for Broccoli: 119.9 degrees Fahrenheit (Fahrenheit unit of measurement), Glazed Apple Square: 55.8 Fahrenheit, Apple juice: 61.6 Fahrenheit, Mocha Mix: 56.3 Fahrenheit. Puree diet for Glazed Apple Square: 52.7 Fahrenheit, Milk:51.2 Fahrenheit, juice 61 Fahrenheit. Verified with the RD and DSS who also conduct the test meal with surveyor. The RD acknowleged pureed Bread Stuffing tasted very salty. The RD stated [NAME] 1 should follow recipe adding milk instead of chicken broth when making pureed Bread Stuffing. The RD explained both ingredients (chicken broth and bread stuffing) had high salt content, by adding both together resulted very salty pureed Bread Stuffing. (Cross reference F 802) On August 20, 2024, at 12:14 p.m., a concurrent interview and MEAL SERVICE policy and procedure review were conducted with the RD and DSS. The RD and DSS acknowledged it took a long time for CNAs sending meal cart to designated area, passing meal trays and also CNAs did not close the meal cart door which could contribute the served foods temperature out of residents' preference. The RD stated served foods out of residents' preference temperature and taste could have potential risk of residents lower their meal intake. During a review of the facility's Policy and Procedure (P&P) titled, MEAL SERVICE, dated 2023, the P&P indicated, . 7. Temperature of the food when the resident receive it is based on palatability. The goal is to serve cold food cold and hot food hot . Recommended Temperature at Delivery to resident .Cold Dessert equal or less than 50 degrees Fahrenheit, Milk/Cold beverage equal or less than 45 degrees Fahrenheit, Vegetable equal or greater 120 degrees Fahrenheit .

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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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50309 Based on observation, interview, and record review, the facility failed to ensure the therapeutic diet order (diet ordered by a physician) and resident preferences were followed for one of 12 residents (Resident 23) when: 1. Resident 23's diet physician order was not implemented and/or provided to the resident. This failure had the potential for Resident 23 to not meet his nutritional needs and not honor his food preferences; and 2. The Registered Dietician's (RD) recommendation to fortify Resident 23's diet was referred to the physician and carried out. This failure had the potential for Resident 23 to have decreased calorie intake and compromise his nutritional status. Findings: 1. On August 19, 2024, at 10:57 a.m., an observation with a concurrent interview was conducted with Resident 23 in his room. Resident 23 stated, he did not like the food served during meals. Resident 23 further stated he did not like fish, pizza, and sandwiches but it was still being served to him. Resident 23 stated he had already tried requesting for hamburger or cheeseburger, but the staff told him it was still frozen. On August 19, 2024, at 12:15 p.m., a concurrent observation and interview was conducted with Resident 23. Resident 23's lunch tray was brought in and the meal ticket indicated, .Regular NAS (no salt added) thin liquids .alert: low potassium fruits and vegetable .alert: double portion .standing orders: 8 oz (ounces - unit of weight measurement), 8 oz sugar free hot chocolate, 2x2 tbsp (tablespoon) of package [NAME] salsa . Dislikes: milk to drink, tuna, fish, sandwiches, pizza . Resident 23's lunch meal consisted of Salisbury steak, corn, rice, vegetable salad, fruit punch and hot chocolate milk. Resident 23 stated he did not like rice and yet he was served rice on his meal tray. Resident 23 further stated the food flavors were not good. On August 21, 2024, Resident 23's record was reviewed. Resident 23 was admitted to the facility on [DATE], with diagnoses that included End-Stage Renal Disease (when the kidneys stop working) on hemodialysis (special procedure done by a trained professional to remove wastes and excess fluids from the body). A review of Resident 23's, History and Physical, dated April 22, 2024, indicated Resident 23 had the capacity to understand and make decisions. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 23's Order Summary, dated, June 20, 2024, indicated, .No Added Salt (NAS) .diet regular texture, thin liquids consistency, SERVE HOT CHOCOLATE .serve omelette if on menu .serve white toast with jelly breakfast daily .serve hamburgers with lunches on Mon, Wed, Fri .serve spaghetti with dinners on Tues, Thurs, Sat .do not serve rice . A review of Resident 23's Care Plan, dated April 22, 2024, indicated, .Malnutrition .Resident is at risk for malnutrition/Potential for weight loss due to possible intolerance to prescribed therapeutic mechanically altered .Interventions/Tasks .Allow adequate time for meal consumption .Cater to food preferences . Encourage adequate nutrition and hydration .Food preferences: soup, yogurt every meal, greens .Add: Mrs. Dash for flavor . A review of Resident 23's Progress Notes, dated June 20, 2024, indicated, .RD Monthly Dialysis Communication Note .Res (sic) (Resident) continues with poor appetite .with multiple meal refusals .noted with wt (sic) (weight) loss of .24 lbs (pounds) since admission about 2 months ago .Wt loss is attributed to Res illnesses/infection and decreased appetite and P.O. (sic) (Oral) intake .Diet order was liberalized to remove renal restriction earlier in the month as well as added foods of Res preference .Also recommended to add fortify to diet order .Summary of Recommendations .D/C (sic) (discontinue) low K+ (sic) (Potassium) fruits and veg(vegetables)-no longer needed .Add fortify .Update dietary preferences to include omelette when scrambled eggs are on the menu. [NAME] toast with butter and jam daily for BF. Hamburger with lunches on Mondays, Wednesdays, and Fridays. Spaghetti with dinners on Tues, Thurs, Saturday. Do not serve rice, Res dislikes . On August 21, 2024, at 4:13 p.m., an interview with a concurrent review of Resident 23's diet order was conducted with the RD, she stated she worked with the renal dialysis RD regarding Resident 23's nutrition and renal health. The RD stated on June 20, 2024, she had recommended to liberalize Resident 23's diet which inlcuded adding the Resident 23's food preference, due to his weight loss. The RD stated Resident 23's current physician diet order was not consistent with his meal ticket record from the dietary department. The RD further stated Resident 23's current physician diet order was not being followed by the dietary department. The RD stated Resident 23's physician diet order should have been followed and implemented. 2. On August 19, 2024, at 12:15 p.m., a concurrent observation and interview was conducted with Resident 23. Resident 23 was alert, interviewable and was waiting for his lunch meal tray to be served in his room. Resident 23's lunch tray was brought in and the meal ticket indicated, .Regular NAS (no salt added) thin liquids .alert: low potassium fruits and vegetable .alert: double portion .standing orders: 8 oz (ounces - unit of weight measurement), 8 oz sugar free hot chocolate, 2x2 tbsp (tablespoon) of package [NAME] salsa . Dislikes: milk to drink, tuna, fish, sandwiches, pizza . Resident 23's lunch meal consisted of Salisbury steak, corn, rice, vegetable salad, fruit punch and hot chocolate milk. In a concurrent interview, Resident 23 stated the food flavors were not good. On August 21, 2024, Resident 23's record was reviewed. Resident 23 was admitted to the facility on [DATE], with diagnoses that included End-Stage Renal Disease (when the kidneys stop working), diabetes (abnormally high level of sugar in blood), and depression. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 23's Order Summary, dated, June 5, 2024, indicated, .NAS (No Added Salt) diet . Regular texture .Thin Liquids consistency. SERVE HOT CHOCOLATE W/ L&D. Serve omelet if on menu. Serve white toast with jelly with breakfast daily serve hamburgers with lunches on Mon, Wed, Fri. Serve spaghetti with dinners on Tue, Thurs, Sat. Do not serve rice . A review of Resident 23's Progress Notes, dated June 20, 2024, and created by the RD, indicated, .RD Monthly Dialysis Communication Note .Resident continues with poor appetite .with multiple meal refusals . noted with wt (weight) loss of .- 24 lbs (pounds) since admission about 2 months ago . Wt loss is attributed to Res illnesses/infection and decreased appetite and P.O. intake. Diet order was liberalized to remove renal restriction earlier in the month as well as added foods of Res preference . Also recommended to add fortify to diet order .Summary of Recommendations .Add fortify . Further review of Resident 23's Progress Notes, indicated that there was no documented evidence that the RD's recommendation to add fortification to Resident 23's diet was referred to the physician and implemented. On August 21, 2024, at 4:13 p.m., an interview with a concurrent review of Resident 23's diet order was conducted with the RD. The RD stated she worked with the renal dialysis RD regarding Resident 23's nutrition and renal health. The RD stated she had recommended on June 20, 2024, to fortify Resident 23's diet because of his weight loss. The RD stated after she made a recommendation, the nursing staff should follow up and communicate to Resident 23's physician and the Director of Nursing (DON). The RD stated she was not sure why Resident 23's current diet order did not include her recommendation to fortify his diet. The RD stated it looked like her recommendation from June 21, 2024, to fortify the diet was not followed up. The RD further stated adding fortify to Resident 23's meals could provide the extra nutrients he may not be getting. During a review of the facility's policy and procedure titled, Therapeutic Diets, dated October 2017, indicated, .Therapeutic diets are prescribed by the Attending Physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences . Diet will be determined in accordance with the resident's informed choices, preferences, treatment goals and wishes . Diet order should match the terminology used by the food and nutrition services department . A therapeutic diet is considered a diet ordered by a physician .or dietitian as part of treatment for a disease or clinical condition to modify specific nutrients in the diet, or to alter the texture of a diet . The attending physician may liberalize the diet at the request of the IDT (if the resident is losing weight or not eating well) or the resident .

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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. 44504 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food preparation and storage practices in the kitchen when: 1. Mold, dust and hair were found in the walk-in refrigerator; 2. Calcium buildup was found on hot water spout; 3. Three wet plastic containers were stacked and stored with dried containers; 4. Dust was observed on several pieces of equipment in the kitchen; 5. Rust was found on several pieces of equipment in the kitchen; 6. Two pieces of equipments in the kitchen had chipped paint; and 7. An unsanitary microwave was found in the [NAME] pantry room These failures had the potential to cause foodborne illness (stomach illness acquired from ingesting contaminated food) in a medically vulnerable population of 128 out of 129 residents who received food prepared in the kitchen. Findings: 1. On August 20, 2024, at 9:35 a.m., a concurrent observation and interview were conducted with the Dietary Service Supervisor (DSS), at the walk-in refrigerator. Two out of two storage shelves were found to have whitish, grayish, and black fuzzy particles on the storage shelves. Besides that, the storage sheleves also found brown debris. Various types of produce were observed stored on the shelves. Hair was found on the milk stored on the right bottom shelf. Two fan covers were observed to be covered with brown debris and the wire next to the evaporator was covered with brown debris. The DSS confirmed the brown debris on the storage shelves, fan covers, and wire was dust and acknowledged the hair on bottom shelf. On August 20, 2024, at 11:03 a.m., a concurrent observation and interview were conducted with the RD and DSS, at the walk-in refrigerator. The RD verified the whitish, grayish, and black fuzzy particles found on the storage shelves were mold. Dust was found on the storage shelves, fan covers, and wire. The DSS stated no Food and Nutrition Service employee was assigned to clean the storage shelves in the walk-in refrigerator. The RD stated an unsanitary walk-in refrigerator could potentially contaminate food stored inside. The RD expectation was to keep the refrigerator clean, dust-free, and mold-free. During a review of the facility's Policy and Procedure (P&P) titled, SANITATION, dated 2023, the P&P indicated, .11. All .equipment shall be kept clean . (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 review of the facility's Policy and Procedure (P&P) titled, REFRIGERATOR AND FREEZER, dated 2023, the P&P indicated, Maintaining a clean refrigerator .can improve the safety and quality of your foods.1. Refrigerator .should be on a weekly cleaning schedule. 2. On August 19, 2024, at 10:44 a.m., a concurrent observation and interview were conducted with the DSS, in the kitchen. The hot water spout found to have white substance buildup. The DSS stated the white substance was calcium from water and the hot water spur should not have calcium buildup. On August 21, 2024, at 9:19 a.m., an interview was conducted with the RD. The RD stated calcium buildup was not supposed to be found on the hot water spout. The RD explained the calcium could contaminate the hot water. During a review of the facility's Policy and Procedure (P&P) titled, SANITATION, dated 2023, the P&P indicated, .11. All .equipment shall be kept clean . 3. On August 19, 2024, at 10:50 a.m., a concurrent observation and interview were conducted with the DSS, in the juice prep area of the kitchen. Three wet plastic containers were observed stacked together and stored with other dried containers. The DSS stated wet plastic containers should not be supposed stacked together or stored with dried containers because moisture inside the wet containers could promote microbial growth. On August 21, 2024, at 9:19 a.m., an interview was conducted with the RD. The RD stated plastic containers need to be air-dried before stacking and storing. During a review of the facility's Policy and Procedure (P&P) titled, DISHWASHING, dated 2023, the P&P indicated, .Dishes are to be air dried in racks before stacking and storing. 4. On August 19, 2024, at 9:24 a.m., a concurrent observation and interview were conducted with the DSS, in the kitchen. Black debris was observed inside the fan of refrigerator number three. The DSS confirmed that the black debris was dust on the fan. The DSS stated the dust should not be found on the fan as it could contaminate the food stored in the refrigeerator. On August 20, 2024, at 9:07 a.m., a concurrent observation and interview were conducted with the DSS, in the dishwashing area. A fan covered with brown debirs was observed blowing directly onto clean dishes. The DSS verified the brown debris was dust on the fan. On August 20, 2024, at 9:10 a.m., a concurrent observation and interview were conducted with the DSS, in the dishwashing area. Diet Aide 1 was observed storing clean dishes on green shelves that were covered with brown debris. The DSS acknowledged the green shelves storing clean dishes were covered with dust and stated the dust could contaminate the clean dishes stored on them. On August 21, 2024, at 9:19 a.m., an interview was conducted with the RD. The RD stated the kitchen should be kept clean and dust-free to prevent contamination of food and clean dishes. During a review of the facility's Policy and Procedure (P&P) titled, SANITATION, dated 2023, the P&P indicated, .11. All .shelves, and equipment shall be kept clean . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On August 19, 2024, at 9:50 a.m., a concurrent observation and interview were conducted with the DSS, in the kitchen's prep juice area. The silver storage shelves used for storing cleaned dishes were found to have brown discoloration. The DSS stated the brown discoloration was rust on the silver storage shelves. On August 19, 2024, at 10:08 a.m., a concurrent observation and interview were conducted with the DSS, in the kitchen. The can opener base was observed to have brown discoloration. The DSS admitted the discoloration was rust on the can opener base. On August 19, 2024, at 10:11 a.m., a concurrent observation and interview were conducted with the DSS, in the kitchen. The pot and pan rack was observed to have brown discoloration. The DSS verified the discoloration was rust on the pot and pan rack. On August 20, 2024, at 9:07 a.m., a concurrent observation and interview were conducted with the DSS, in the dishwashing area. The drying dome (plastic cover used to keep food warm) rack had brown discoloration. The DSS confirmed the discoloration was rust found on the drying dome rack. On August 20, 2024, at 10:51 a.m., a concurrent observation and interview were conducted with the RD and DSS, in the dry storage room. Seven out of 14 silver storage shelves had brown discoloration. The RD and DSS acknowledged the brown discoloration on the silver storage shelves was rust. On August 21, 2024, at 9:19 a.m., an interview was conducted with the RD. The RD stated rust should not be found on shelves and equipment, as it could potentially cause cross-contamination. The RD stated her expectation was that no rust should be present on equipment or shelves found in the kitchen. During a review of the facility's Policy and Procedure (P&P) titled, SANITATION, dated 2023, the P&P indicated, .11. All .shelves, and equipment .shall be free from .corrosions, . 6. On August 19, 2024, at 9:57 a.m., a concurrent observation and interview were conducted with the DSS, in the kitchen. The mixer paint coating was observed to have chipped coating, exposing metal. The DSS stated, The mixer is old; need to buy a new one and the paint coating already peeled off. On August 19, 2024, at 10:03 a.m., a concurrent observation and interview were conducted with the DSS, in the kitchen. The DSS confirmed the utensil hanger had chipped paint. On August 21, 2024, at 9:19 a.m., an interview was conducted with the RD. The RD stated the utensil hanger needed to be repaired to fix the chipped paint and the mixer needed to be replaced to prevent cross-contamination. During a review of the facility's Policy and Procedure (P&P) titled, SANITATION, dated 2023, the P&P indicated, .11. All .equipment .shall be free from .chipped areas. 7. On August 20, 2024, at 8:50 a.m., a concurrent observation and interview were conducted with the Registered Nurse (RN) 2, in the [NAME] pantry room. The microwave was found to have splashed black and brown particles inside. RN 2 stated the microwave was used to warm up residents' food and confirmed that the microwave was unsanitary. RN stated that a dirty microwave was an infection control issue that could potentially cause cross-contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On August 21, 2024, at 9:19 a.m., an interview was conducted with the RD. The RD stated the microwave needed to be cleaned after each use to prevent cross-contamination. During a review of the facility's Policy and Procedure (P&P) titled, SANITATION, dated 2023, the P&P indicated, .11. All .equipment shall be kept clean .

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. 50204 Based on interview and record review the facility, which has more than 120 beds, failed to employ a full-time qualified social worker. This failure had the potential in residents not receiving the necessary treatment and health services provided by a qualified social worker. On August 23, 2024, at 4:30 p.m., the Administrator (ADM) was notified an extended survey would be conducted due to substandard quality of care issues. Findings: On August 23, 2024, at 12:27 p.m., during a concurrent interview and review of the social worker employment requirements with the (SSD), she stated she had been employed in the facility for one year and one month as a full-time Social Service Director for the facility. The SSD stated she did not have a bachelor's degree in social work, and she is not a licensed medical social worker. The SSD further stated she is not supervised by a qualified social worker. The SSD stated she is not qualified to perform psychosocial assessments to residents which had the potential to cause physical and psychosocial distress. On August 23, 2024, a review of the Social Service Director (SSD) personnel file indicated that the SSD had a proficiency certificate in social work designee training in 2008. There was no indication the SSD had a bachelor's degree in social work or in a human services field. On August 23, 2024, at 1:20 p.m., during an interview with the ADM, he stated the SSD is not supervised by a qualified social worker. The ADM stated, the SSD was not qualified to fulfill the responsibilities of a social worker for a facility with a licensed capacity of 132 beds. A review of the facility document titled, Job Description: Social Service Staff, dated March 2017, indicated, . Qualification .Education .Bachelors degree in Social Work or in Human Services . A review of facility policy and procedure titled, Social Services, dated October 2010, indicated, .The Director of Social Services is a qualified social worker .provides medically related social services to assure that each resident can attain or maintain his/her highest practicable physical, mental, or psychosocial well-being .

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 47202 Based on interview and record review, the facility failed to ensure the Quality Assessment and Performance Improvement (QAPI) identified concern regarding narcotic (a controlled drug that can cause paralysis or loss of feeling) medication accountability and pain assessment before and after pain medication administration was monitored and evaluated. This failure had the potential for possible diversion of controlled medication and for residents to experience unrelieved and unmanaged pain which could compromise the resident's overall health and wellbeing. Findings: On August 23, 2024, at 4:53 p.m., a concurrent interview and record review of the facility QAPI meeting were conducted with the Administrator (ADM) and the Director of Nursing (DON). The DON stated the QAPI meetings on February 26, 2024 and April 30, 2024 identified the following concerns: - Narcotic medications being signed out on the narcotic count sheet by License Nurses (LN) but were not being documented as administered in the e-MAR (Electronic Medication Administration Record), and - Pain assessments, monitoring and evaluations were not being conducted by the LN's after pain medication administration. The DON stated the Pharmacy Consultant conducted audits to assess the LN's competency, and all facility nurses received education and training related to medication administration and pain assessment. The DON further stated the facility did not monitor and re-evaluate the effectiveness of the interventions implemented. The DON stated the facility should have re-evaluated and monitored the effectiveness of the interventions to ensure the safety and accountability of narcotic medications and to ensure that residents pain was managed preventing unrelieved pain that could affect the residents' overall physical and psychosocial health and wellbeing. A review of the facility policy and procedure titled, Quality Assurance Performance Improvement (QAPI) - Feedback, Data, and Monitoring, dated march 2020, indicated, .The QAPI .focuses on identifying systems and process that may be problematic and could be contributing to avoidable negative outcomes related to resident care, quality life, resident safety .and making good faith effort to correct or mitigate there outcomes . Corrective actions and performance improvement activities are initiated and monitored .The committee tracks and documents the progress of existing initiatives .as part of the ongoing QAPI process .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50204 Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented when: 1. Certified Nursing Assistant (CNA) 4 did not clean and disinfect (use of chemicals to reduce the number of bacteria or virus particles on surfaces) the Hoyer lift (mechanical device use for lifting) before and after resident use. 2. Registered Nurse (RN) 3 did not wear personal protective equipment (PPE - equipment use to protect against infection or illness) when taking care of a resident with Extended Spectrum Beta Lactamase (ESBL - a bacteria resistant to many antibiotics [medication use to treat infections]). These failures had the potential to increase the spread of pathogens (germs) and infections from staff to residents which could lead to illness or death. Findings: 1. On August 20, 2024, at 9:02 a.m., during a concurrent observation and interview with CNA 4, CNA 4 was observed coming out of Resident 105's room and entering Resident 18's room with the Hoyer lift. CNA 4 used the Hoyer lift to transfer Resident 18 to a Gerichair (specialized chair to provide support and comfort). CNA 4 did not clean the Hoyer lift before using it with Resident 18. CNA 4 stated she did not clean and disinfect the Hoyer lift. CNA 4 further stated she should have cleaned and disinfected the Hoyer lift to prevent the spread of infection to Resident 18 and other facility residents. On August 22, 2024, at 9:16 a.m., during an interview with the Infection Preventionist Nurse (IPN), he stated Resident 18 was on enhance barrier precaution for ESBL. The IPN further stated CNA 4 should have cleaned and disinfected the Hoyer lift in between use. On August 22, 2024, Resident 18's record was reviewed. Resident 18 was admitted to the facility on [DATE], with diagnosis which included ESBL. A review of Resident 18's History and Physical, dated May 17, 2024, indicated Resident 18 had the capacity to understand and make decisions. A review of Resident 18 Order Summary, dated May 29, 2024, indicated, .Enhanced Barrier Precautions (a type of Transmission Base Precautions [TBP] - measures use to prevent the spread of infections) .Staff must wear gloves and gowns (PPE) . 2. On August 21, 2024, at 11:25 a.m., during a concurrent observation and interview with RN 3, RN 3 was observed administering intravenous (IV - directly into a vein) medication to Resident 18 and changing dressing of Resident 18's left upper arm IV site without a PPE. RN 3 stated she provided care to Resident 18 and did not wear PPE. RN 3 further stated she should have worn PPE to prevent the spread of pathogens and protect the facility residents from infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On August 22, 2024, at 9:16 a.m., during an interview with the Infection Preventionist Nurse (IPN), he stated Resident 18 was on enhance barrier precaution for ESBL. The IPN further stated RN 3 should have worn PPE before providing care to Resident 18 to prevent the spread of infection to other facility residents. On August 22, 2024, at 2:39 p.m., during an interview with the Director of Nursing (DON), she stated the expectation was for the staff to follow the facility infection control policy and procedure. The DON further stated CNA 4 should have disinfected the Hoyer lift and RN 3 should have worn PPE to prevent the spread of infection to the facility residents. A review of policy and procedure titled, Infection Prevention and Control Program, dated October 2018, indicated, .Is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections .

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 44504 Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to ensure the facility remained free of pests when house flies were found in the kitchen and East activity room. This failure had the potential to spread bacteria from flies, which could cause illness in a medically vulnerable population of residents. Findings: On August 19, 2024, at 10:52 a.m., a concurrent observation and interview were conducted with the Dietary Service Supervisor (DSS) in the kitchen at the prep juice area. A house fly was observed landing on a cleaned plastic container. The DSS stated the delivery man propped the door open, which allowed the house fly to enter the kitchen. On August 20, 2024, at 12:41 p.m., a concurrent observation and interview were conducted with Certified Nurse Assistant (CNA) 3 in the East activity room. A house fly was observed landing on Resident 41's served food. CNA 3 stated the house fly entered the room when other residents opened the door to go outside to smoke. On August 21, 2024, at 9:19 a.m., an interview was conducted with the Registered Dietitian (RD). The RD stated the house fly carry bacteria which could contaminate food, and the facility should not have any pests. During a review of the facility's Policy and Procedure (P&P) titled, PEST CONTROL, revised May 2008, the P&P indicated, Our facility shall maintain an effective pest control program. Policy Interpretation and Implementation: 1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects . During a review of the facility's Policy and Procedure (P&P) titled, MISCELLANEOUS AREAS, dated 2023, the P&P indicated, .FLY AND VERMIN CONTROL Flies are carries of disease and are a constant enemy of high standards of sanitation in the Food & Nutrition Services Department.