STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555470	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wagner Heights Nursing & Rehabilitation Center	9289 Branstetter Place Stockton, CA 95209

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 40583 Based on interview and record review, the facility did not ensure one of 41 sampled residents (Resident 118) was treated with dignity and respect, when Resident 118 heard certified nursing assistant (CNA) 2 speaking negatively about her to licensed nurse (LN) 2. This failure resulted in Resident 118 feeling upset and crying, negatively impacting Resident 118's feelings of self-worth (the internal sense of being good enough and worthy of love and belonging from others) and self-esteem (how you value and perceive yourself, and the degree to which you think your qualities are positive). Findings: A review of Resident 118's Admission Record, indicated Resident 118 was admitted to the facility in Fall 2023, with diagnoses which included obesity. During an interview with Resident 118, on 11/5/24, at 12:33 PM, Resident 118 stated CNA 2 called her fat. Resident 118, being tearful when recounting the situation, further stated CNA 2 told her that it hurt his arms to push her in her wheelchair because she was fat and asked her why she had to go outside all the time. Resident 118 stated it made her feel bad and it hurt her feelings and she would cry. Resident 118 explained she told her nurse [LN 2] and said she did not want CNA 2 taking care of her anymore. Resident 118 further explained Social Services did not follow up with her after her initial complaint. (Social Services-assess and address emotional and psychosocial needs, develop and implement care plans, and advocate for residents). A review of Resident 118's clinical document titled, Grievance/Complaint Resolution Report, dated 10/10/24, indicated, .Does not want [CNA 2] says rude stuff/things to her keeps saying slick [sic] remarks about how big she is and about her w/c [wheelchair] is too big. He does not want to work, that she hurts his back .[CNA 2] stated that he spoke to his nurse about resident and didn't realize it was close enough to hear .[CNA 2] was given a write up with in-service to follow on communication . During an interview with LN 2, on 11/5/24, at 2:37 PM, LN 2 stated Resident 118 told him CNA 2 hurt her feelings and that CNA 2 said she hurt his back in front of her. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Social Services Director (SSD), on 11/5/24, at 2:44 PM, the SSD stated Resident 118 told her CNA 2 was making statements about her that she was uncomfortable with and that her wheelchair was too big, and it was hurting his back. During an interview with CNA 2, on 11/5/24, at 2:48 PM, CNA 2 explained Resident 118 must have overheard him talking to LN 2. CNA 2 further explained he told LN 2 it was hard on him physically having Resident 118 5-6 days a week. CNA 2 stated the Director of Staff Development (DSD) spoke to him regarding Resident 118 and informed him he needed to be professional, and he received a verbal in-service on professionalism and communication with residents, and included not saying anything negative in front of residents. During an interview with the DSD, on 11/5/24, at 3:07 PM, the DSD stated CNA 2 was given a written warning and removed from working with Resident 118's group. The DSD explained CNA 2 stated Resident 118 was heavy and was hurting his back, not realizing Resident 118 overhead him. The DSD further explained Resident 118 was upset, and did not want CNA 2 working with her anymore. During an interview with the SSD, on 11/5/24, at 3:17 PM, the SSD stated Resident 118's care plan should have been updated regarding the situation with CNA 2, and the care plan was not updated. The SSD further explained no one from the social services department followed up with Resident 118 regarding how she was doing and feeling after the incident, and they should have. The SSD acknowledged there were no social services notes regarding follow up visits to Resident 118. During an interview with the Assistant Director of Nursing (ADON), on 11/8/24, at 12:28 PM, the ADON stated the importance of not letting residents overhear staff making negative comments about them was to ensure residents maintained their dignity. The ADON further explained it was degrading to Resident 118 and residents should be treated with respect. A review of the facility supplied document titled, Resident [NAME] of Rights, dated 5/2011, indicated, .To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs . A review of the facility policy titled, Care Plan, Episodic, dated August 2014, indicated, .It is the policy of this facility to develop an episodic/short term care plan for acute temporary changes and/or condition . communicate resident's specific problem and approaches to establish guidance to all disciplines on meeting the individual needs of the resident .

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 43943 Based on observation, interview, and record review, the facility failed to ensure 3 of 41 sampled residents (Resident 21, Resident 94, and Resident 50) needs were accommodated based on their physical limitations when, 1. Resident 21 was unable to easily use a push button call light (a handheld device with a button to call for staff assistance) and was not assessed for the need of an adaptive call light (a device that allows people with limited hand function to call for assistance); 2. Resident 94 was unable to easily use a push button call light, was not assessed for the need of an adaptive call light, and Resident 94's fall mat (a soft pad used to reduce risk of injury in case of a fall) was not in place near the bed; and, 3. Resident 50's wheelchair was lost, and the facility provided him with a wheelchair which was too large, uncomfortable, and did not fit through his door. These failures placed Resident 21 and Resident 94 at risk for falls, injury, and psychosocial distress when both residents were unable to easily call for assistance from staff, and placed Resident 50 at risk for emotional distress and feelings of isolation. 1. A review of Resident 21's clinical record titled, Admission Record (a document that contains demographic information), indicated Resident 21's diagnoses included stroke (the brain was deprived of oxygen for an amount of time to cause brain injury) and contracture (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) of the left hand, and weakness on one side of the body. During a concurrent observation and interview on 11/6/24. at 2:30 p.m., with the Minimum Data Set Nurse (MDS - a nurse who completes a comprehensive assessment), Resident 21's left hand was observed to have contractures and her right hand was weak. MDS asked Resident 21 to press the call light. Resident 21 was unable to place the call light in her hand or press the call light button. MDS placed the call light in Resident 21's right hand and after two minutes of encouragement and multiple prompts, Resident 21 was finally able to press the call light. Resident 21 was crying and stated sometimes she would press the call light, and no one would come to the room to help her. MDS stated Resident 21 would benefit from an adaptive call light in which Resident 21 could touch a pad instead of having to press a button to get the call light to activate. MDS stated Resident 21 was at risk for falls and that not having an adaptive call light to request staff assistance put her at risk for falls and injury. During an interview on 11/6/24, at 3:49 p.m., with the Restorative Nursing Assistant 1 (RNA - provides exercises to the residents), RNA 1 stated Resident 21 had not been assessed by nursing or physical therapy for her ability to use a conventional call light. RNA 1 stated Resident 21 had been in the same room since her admitted and had the same type of call light during her stay at the facility. RNA 1 stated Resident 21 would benefit from an adaptive call light that would not require her to push a button. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 21's clinical record titled, Section GG - Functional Abilities (a portion of a comprehensive assessment), dated 10/4/24, indicated Resident 21 utilized a wheelchair and was dependent on staff for transferring from one location to another, bathing, rolling from side to side, showering, and dressing. A review of Resident 21's clinical record titled, Fall Risk Assessment (an assessment that assists in evaluating risk factors and recent fall history), dated 2/15/24, indicated Resident 21 was at high risk for falling (score 50) related to her state of bedrest, impaired gait (style of walk), and that Resident 21 overestimated her physical abilities. A review of Resident 21's clinical record titled, Care Plan (a document which indicated Resident 21's individual problems, goals, and interventions), dated 12/12/18, indicated Resident 21 was at risk for falls and injuries related to medications and a history of stroke. Interventions included to keep the call light within reach and to encourage the use of the call light. A review of Resident 21's clinical record titled, Care Plan, dated 12/19/18, indicated Resident 21 had impaired thought process, memory loss, and impaired decision making related to dementia (a general term for a decline in mental abilities that affects a person's daily life). Interventions included supervision as needed. 2. A review of Resident 94's clinical record titled, Admission Record indicated Resident 94's diagnoses included dementia (a general term for a decline in mental abilities that affects a person's daily life), hemiplegia and hemiparesis (inability to move one side of the body) following a stoke (oxygen deprivation to the brain for an amount of time causing brain damage), and hallucinations (seeing things that were not real). During a concurrent observation and interview with Resident 94 and Licensed Nurse (LN) 1, on 11/5/24 at 10:00 a.m., LN 1 verified Resident 94's call light was hanging off the right side of her bed and not in reach and the fall mat (a soft mat placed at the side of the bed to help cushion a fall) was pushed away (approximately 4 feet) from the right side of Resident 94's bed. LN 1 asked Resident 94 if she could reach her call light, and Resident 94 stated, no. LN 1 then handed Resident 94 her call light and prompted her to press the call light button. Resident 94 was unable to push the button due to weakness in her hands. LN 1 stated Resident 94 was a high risk for falls and should have had an adaptive call light (a call light that required the resident to tap on a pad instead of pushing a button) and the fall mat should have been pushed up close to the side of the bed. A review of Resident 94's clinical record titled, Fall Risk Assessment, dated 10/11/04, indicated Resident 94 was a high risk for falls (score of 50) related to her medical diagnoses of dementia and stroke and Resident 94 overestimated her ability to walk. During a review of Resident 94's clinical record titled, Care Plan, dated 10/14/24, indicated Resident 94 took specific medications that placed her at a safety risk and potential injury. During a review of Resident 94's clinical record titled, Section GG Functional Abilities - Admission (a section of a comprehensive assessment), dated 10/16/24, indicated Resident 94 was dependent on staff for eating, oral hygiene, toileting hygiene, shower/bath, upper and lower dressing, and rolling from side to side. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Policy and Procedure (P&P) titled, Fall Prevention and Response, dated 8/23, indicated, . Each Resident will be assessed for fall risk factors and will receive care and services in accordance with individualized level of risk to minimize the likelihood of falls . During a concurrent interview and record review on 11/7/24, at 2:39 p.m., with the Director of Nursing (DON) and Administrator (ADM), the Policies and Procedures (P&Ps) titled, Accommodation of Needs Positive Practice, dated 11/2017, and Call Lights: Accessibility and Timely Response, dated 10/2022, were reviewed. Accommodation of Needs Positive Practice, indicated, . The facility will ensure that the physical environment will aid residents to maintain independent functioning which includes . supportive and adaptive . equipment . Call Lights: Accessibility and Timely Response, indicated, .Each resident will be evaluated for unique needs and preferences to determine any special accommodations that may be needed for the resident to utilize the call system . The DON and ADON acknowledged the policies were not followed. 50161 3. Review of Resident 50's ADMISSION RECORD indicated Resident 50 was admitted to the facility in 2022, with diagnoses including respiratory failure, morbid obesity, and abnormalities of gait and mobility. During an interview on 11/5/24, at 11 a.m., Resident 50 stated he had lived at the facility for two and a half years. Resident 50 stated he had his own wheelchair but earlier in the year while he was admitted to the hospital, the facility sent it home with another resident. Resident 50 stated the facility gave him an alternate wheelchair, but it was too big to fit in his doorway. Resident 50 stated when he tried to use the wheelchair he slid down and did not feel safe in it. Resident 50 stated he has told staff the wheelchair was too large. Resident 50 stated he last used his current wheelchair a couple of months ago. In a concurrent observation and interview on 11/8/24, 9:29 a.m., with Resident 50 in his room, Resident 50 stated the current wheelchair had no footrests, was too big, and stated he felt like he was swimming in it. Resident 50 stated this caused him to start hyperventilating, so he was scared to use it. Resident 50 stated he wanted his independence back. During a concurrent interview and record review on 11/8/24, at 9:59 a.m., with the Director of Rehabilitation (DOR), the DOR stated the wheelchair Resident 50 currently used was too large, so she measured him, and told Central Supply Staff (CS) he needed a 30-inch wheelchair. The DOR stated his current wheelchair was a size 34. The DOR stated she told the CS on about 10/11/24 and stated she did not think it should take a month for the resident to receive a new wheelchair. The DOR stated she spoke to the CS yesterday regarding the wheelchair order and was told the CS ordered it yesterday. The DOR stated Resident 50 would be more comfortable in a smaller wheelchair. The DOR stated if the wheelchair was too big, he could slide out and fall. During an interview on 11/8/24 at 10:55 a.m., the CS stated she received the request a month ago, but the 30-inch wheelchair was not available, so they ordered a size 28, which would be delivered on 11/18/24. The CS indicated if their normal vendor could not locate an item they could have used an alternate vendor. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility email receipt, dated 11/7/24, indicated an order was placed through an outside vendor for a wheelchair with a seat width of 28 inches. During an interview on 11/8/24, at 11:10 a.m., Certified Nursing Assistant (CNA) 3 stated Resident 50 wanted to be able to get up, and stated he was not comfortable in his wheelchair. CNA 3 stated she had informed the nurses. During an interview on 11/8/24 at 12:58 p.m., with the Assistant Director of Nursing (ADON) 2, ADON 2 stated, .He should have a wheelchair that fits him . ADON 2 indicated he would be safer and more motivated to get up. During an interview on 11/8/24 at 1:10 p.m., Restorative Nursing Assistant (RNA) 1 stated Resident 50 was up in his wheelchair often in the summer of 2023, and stated, .he was doing great. He was happy and in chair . During an interview on 11/8/24 at 1:21 p.m., Licensed Nurse (LN) 9 stated Resident 50 could no longer transfer into his wheelchair and stated it had been about three months since his wheelchair went missing. LN 9 stated, He has the wheelchair that's too big. That is why he cannot walk or stand . During a review of the facility's Policies and Procedures titled, Accommodation of Needs Positive Practice, dated 11/2017, the policy indicated, . The facility will ensure that the physical environment will aid residents to maintain independent functioning which includes . supportive and adaptive . equipment .

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 50161 Based on interview and record review, the facility failed to consult the physician for 1 of 41 sampled residents (Resident 50) when Resident 50's physician recommended exercise in response to Resident 50's request for help with weight loss, and the facility did not notify Resident 50's physician of his inability to participate in an exercise program. This failure had the potential for a delay in interventions to assist Resident 50 with his goals for weight loss and to experience feelings of hopelessness. Findings: Review of Resident 50's ADMISSION RECORD, indicated Resident 50 was admitted to the facility in 2022, with diagnoses including morbid obesity and abnormalities of gait and mobility. Review of Resident 50's [facility name] Fax Notification /Order Transmittal, dated 7/24/24, indicated, .To doctors .Primary Concern / Reason for the fax .The resident was researching weight loss medications and discovered [semaglutide; an anti-obesity medication used for long-term weight management] injections 1x [time] a week. The resident want [sic] to try it. Please advise .current weight .417 lbs [pounds] .RNA [restorative nursing assistant] to assist with walking & exercise . PHYSICIAN SIGNATURE [signature of Nurse Practitioner (NP) 1] . The document indicated it was signed by NP 1 on 7/26/24. Review of Resident 50's Order Summary Report, dated 7/26/24 indicated, .RNA with walking and exercise . The document indicated the order was discontinued and was not completed. Review of Resident 50's Mini Nutrition Note, dated 10/10/24, written by the Registered Dietician (RD) indicated, . [Resident 50] presents with a significant weight gain of +22# [a 22-pound gain] x1month. Intake is good .BMI is 61.1, which is obese .Weight loss would be beneficial. [Resident 50] desires weight loss but states he continues to eat because he has nothing else to do and expresses demoralization to start the process d/t [due to] previous failures of change. RD encouraged weight loss . During a concurrent interview and record review on 11/8/24 at 12:58 p.m., with the Assistant Director of Nursing (ADON) 2, ADON 2 reviewed Resident 50's clinical record and indicated on 7/26/24 NP 1 recommended weight loss through exercise with RNA services. ADON 2 explained Resident 50 had been refusing as he could not walk. ADON 2 was not sure if this problem had been shared with the physician or NP 1. During an interview on 11/8/24 at 1:10 p.m., Restorative Nursing Assistant (RNA) 1 stated Resident 50 was up in his wheelchair often in the summer of 2023, and stated, .he was doing great. He was happy and in chair . RNA 1 stated Resident 50 was able to participate in sit and stand exercises in 2023. RNA 1 stated Resident 50's weight affected his breathing, and he could not tolerate the exercises now, or even being up out of bed. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/8/24 at 1:16 p.m., ADON 2 stated, .resident not exercising and walking with RNA should have been communicated with doctor . ADON 2 explained this was important so that other options for Resident 50's goal to lose weight could be discussed. ADON 2 stated there was no evidence in Resident 50's clinical record of updates to the physician regarding Resident 50's decline of functional abilities and his inability to follow an exercise program. ADON 2 stated the facility should have asked Resident 50 if he still wanted to try the weight loss medication. During a review of a facility policy and procedure titled Resident [NAME] of Rights, undated, the document indicated, .To be fully informed by a physician of his or her total health status and to be afforded the opportunity to participate on an immediate and ongoing basis in the total plan of care including the identification of medical, nursing, and psychosocial needs and the planning of related services .To be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs .The resident has a right to a dignified existence, self-determination .

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 40583 Based on interview and record review, the facility failed to maintain 2 of 41 sampled residents (Resident 89 and Resident 95) personal privacy and confidentiality of medical records when Resident 89's medical record contained Resident 95's personal health information (PHI). This failure resulted in Resident 95's PHI being available to Resident 89, violating Resident 95's right for confidentiality of his PHI. Findings A review of Resident 95's Admission Record, indicated Resident 95 was admitted to the facility with diagnoses which included anxiety disorder and depression. A review of Resident 89's Admission Record, indicated Resident 89 was admitted to the facility with diagnoses which included depression. A review of Resident 89's Electronic Health Record [HER] revealed a clinical document titled, Consultation Report, dated May 1, 2024, through May 16, 2024. The document belonged to Resident 95 and was filed in Resident 89's EHR. Resident 95's document contained PHI including Resident 95's birthdate, gender, a medication Resident 95 was receiving, and a recommendation for lab work which needed to be completed. During an interview with the Medical Records Director (MRD), on 11/6/24, at 11:29 AM, the MRD acknowledged Resident 95's PHI was in Resident 89's EHR. The MRD explained it was important resident clinical records which contained PHI were filed correctly to protect confidentiality and privacy. During an interview with the Assistant Director of Nursing (ADON) , on 11/8/24, at 12:27 PM, the ADON explained Resident 95's consultation report included confidential information and contained some of Resident 95's health history and personal information. A review of the facility policy titled, HIPPA [Health Insurance Portability and Accountability Act-a federal law that protects the privacy of individuals' health information] Privacy Policies, reviewed 10/15/19, indicated, . Review and Prepare Record .Remove any portion of the record relating to someone other than resident . A review of a facility supplied document titled, Resident [NAME] of Rights, dated 5/2011, indicated, .To be assured confidential treatment of financial and health records and to approve or refuse their release . A review of a document from the Centers for Disease Control and Prevention titled, Health Insurance Portability and Accountability Act of 1996 (HIPAA), dated 9/10/24, indicated, The Health Insurance Portability and Accountability Act (HIPAA) of 1996 establishes federal standards protecting sensitive health information from disclosure without patient's consent. The US Department of Health and Human Services issued the HIPAA Privacy Rule to implement HIPAA requirements. The HIPAA Security Rule protects specific information cover the Privacy Rule. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47369 Based on observation, interview, and record review, the facility failed to ensure that 2 of 41 sampled residents' (Resident 51 and Resident 102) Minimum Data Set (MDS -a federally mandated resident assessment and screening tool which identifies care needs) assessments reflected their current status when: 1. Resident 51's discharge MDS was not completed for discharge in July 2024 2. Resident 102's route of feeding was not correct on the MDS assessment. These failures had the potential for Resident 102's strengths and needs to go unassessed which could have resulted in inaccurate or missing individualized care plans, and led to Resident 51's health status upon discharge not being tracked in the MDS system. Findings: 1. A review of Resident 51's ADMISSION RECORD, indicated he was admitted to the facility in June of 2024. A review of Resident 51's clinical document titled, [NAME] Notice of Transfer or Discharge, indicated, . Effective Transfer or discharge date .07/19/2024 . A review of a facility audit list of Resident 51's completed MDS assessments indicated, Discharge .7/19/2024 .Complete by: 8/2/24- 97 days overdue .Description .Discharge Return Not Anticipated .Status .In Progress . A review of a facility provided document titled, RAI . [Resident Assessment Instrument] -required Assessment Summary, indicated, .Assessment Type .Discharge assessment-return not anticipated .MDS Completion Date .No Later Than .discharge date + 14 calendar days .Transmission Date No Later Than . MDS Completion Date + 14 calendar days . During a concurrent interview and record review on 11/7/24, at 7:51 AM, the MDS coordinator (MDSC) confirmed Resident 51's discharge assessment was incomplete. The MDSC stated the discharge assessment was important to track the status of the resident and to mirror the true census of the facility. The MDSC stated if the assessment was not completed, the Centers for Medicare Services (CMS) would not be informed of Resident 51's discharge status. A review of a facility policy and procedure titled, MDS STANDARD OF PRACTICE, dated 10/2022, indicated, . It is the practice of this facility to conduct accurate coding and delivery of services provided to capture accurate assessment of each resident's functional capacity and health status as per CMS RAI MDS 3.0 Manual guidelines .MDSs are transmitted within the timeframe's set forth in the CMS RAI MDS 3.0 Manual . (continued on next page)

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	555470	A. Building B. Wing	11/08/2024

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of an online document retrieved 11/13/24, at 8:19 AM, from https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/SNF-PPS/SNFA, Titled, MEDICARE -REQUIRED SNF PPS [skilled nursing facility prospective payment systems] ASSESSMENTS, dated, 10/2017, indicated, .Medicare -Required Discharge Assessments .are intended to collect the standardized data to calculate quality measures [measures used to determine a nursing home's star rating] . 43943 2. A review of Resident 102's clinical record titled, Admission Record (a document that contains demographic information), indicated Resident 102's diagnoses included respiratory failure. A review of Resident 102's clinical record titled, Orders, dated 5/24/24 through 10/22/24, indicated Resident 102 was on a pureed diet (diet consists of foods that are ground, mashed, or blended until they are smooth and soft, like pudding). A review of Resident 102's clinical record titled, Section K - Swallowing/Nutritional Status (a section of a comprehensive assessment), dated 8/12/24, indicated Resident 102 required a feeding tube (a tube placed in the nose or in the stomach that directly delivers food to the body, often by a pump device) to receive her food. During a concurrent observation and interview on 11/5/24, at 9:38 a.m., with Certified Nursing Assistant (CNA) 1, CNA 1 verified there was not a feeding pump next to Resident 102's bedside. CNA 1 stated Resident 102 had never received food via a feeding tube. During a concurrent interview and record review on 11/7/24, at 7:57 a.m., with the Minimum Data Set Nurse (MDS - a nurse who completes the comprehensive assessment), Resident 102's Electronic Health Record (EHR) was reviewed. MDS acknowledged that while at the facility, Resident 102 had never used a feeding tube to receive nutrition, and that the data which indicated Resident 102 received food via a feeding tube was entered in error. During a joint concurrent interview and record review on 11/7/24, at 2:39 p.m., with the Director of Nursing (DON) and the Administrator (ADM), the facility's document titled, MDS Standard of Practice, dated 10/2022, was reviewed. The document indicated, . It is the practice of this facility to conduct accurate coding and delivery of services provided to capture accurate assessment of each resident's functional capacity and health status . check the Final Validation Report for critical and data integrity errors . The DON and ADM acknowledged the facility's MDS Standard of Practice document was not followed.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. 43943 Based on interview and record review, the facility did not ensure 1 of 41 sampled residents (Resident 43) had her Preadmission Screening and Resident Review (PASARR- a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes) form updated after a significant change in a mental illness diagnosis. This failure resulted in Resident 43 not receiving an updated screening assessment that could have provided services needed to improve Resident 43's mental health condition and quality of life. Findings: A review of Resident 43's clinical record titled, Preadmission Screening and Resident Review (PASARR) Level 1 Screening, dated 11/3/23, indicated Resident 43 had a diagnosis of a serious mental illness, and therefore the Level I screening was positive and required a Level II screening (an evaluation to determine if the resident could benefit from specialized mental health services). A review of Resident 43's clinical record titled, Admission Record (a document that contains demographic information), indicated Resident 43's diagnosis was updated on 2/22/24 to include schizoaffective disorder (a chronic mental disorder that can cause one to see and believe things that are not real, feelings of intense sadness, higher energy levels, and depression). During a joint concurrent interview and record review on 11/7/24, at 9:25 a.m., with the Admissions Department (ADD) and the Admissions Department Manager (AM), Resident 43's clinical record titled, Level II Evaluation, dated 11/3/23, was reviewed. The document indicated, . After reviewing the Positive Level I Screening and speaking with staff, a Level II mental Health Evaluation was not scheduled for the following reason: The individual has no serious mental illness (SMI) . To reopen, please submit a new Level I Screening . The ADD and ADM stated a new PASARR Level I should have been completed after Resident 43 received her new mental illness diagnosis. The ADD and AM stated the admission department was in charge of initiating the PASARRs when a new mental health diagnosis had been identified and the information has been given to them by the Minimum Data Set Nurse (MDS - A nurse who completes comprehensive assessments on residents of the facility). The ADD and AM stated a new screening should have been completed to ensure Resident 1 received the correct specialized services and to ensure recommendations for treatment were followed. During an interview on 11/7/24, at 9:51 a.m., with the MDS Nurse, the MDS nurse stated he was unsure how the admissions department was made aware of Resident 43's new mental health diagnosis and was unsure when a PASARR re-screen needed to be completed. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a joint interview and record review on 11/7/24, at 2:39 p.m., with the Director of Nursing (DON) and Administrator (ADM), the facility's document titled, California Department of Health Care Services Preadmission Screening and Resident Review (PASARR), dated 1/12/23, was reviewed. The document indicated, . The Level I Screening should always reflect the individual's current condition. We recommend checking if a Resident Review is needed during a facility's annual or quarterly MDS review . The DON and ADM acknowledged an updated Level I screening should have been competed to reflect Resident 43's most current mental health illness diagnosis. The DON and ADM stated the policy was not followed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49823 Based on interview and record review, the facility failed to ensure 2 of 41 sampled residents (Resident 54 and Resident 94) had individualized care plans (a document that indicates specific problems, goals, and interventions) developed and implemented when: 1. Resident 54's vision care plan was not developed to include admitting diagnoses of diabetic cataract (a clouding of the eye's lens that can lead to decreased vision and blindness) and glaucoma (a chronic eye disease that occurs when fluid builds up in the eye causing gradual loss of sight); and, 2. Resident 94's care plan to address falls was not developed. These failures could have resulted in Resident 54's care needs not being addressed, and Resident 94 could have sustained a preventable fall which could have resulted in an injury. Findings: 1. A review of Resident 54's Admission Record indicated Resident 54 was admitted to the facility in 2024 with diagnoses which included diabetic cataract and glaucoma. During a review of Resident 54's Clinical Case Management Progress Note dated 6/5/24, the note indicated Resident 54 informed the staff he was taking eye drops which were not on his current medication list. The note further indicated staff placed a call to Resident 54's physician regarding the ophthalmic medication (used to treat eye disorders) for Resident 54. A review of Resident 54's Physician Order Summary dated 6/5/24 indicated Resident 54 was ordered Brimonidine Tartrate Ophthalmic Solution (medicated eye drops) one drop in both eyes three times a day for glaucoma, Timoptic Ophthalmic Solution, one drop in both eyes two times a day for glaucoma, and Latanoprost Ophthalmic Solution, one drop in both eyes in the evening for glaucoma. A review of Resident 54's Care Plan indicated Resident 54 had no vision care plan developed with focus or interventions listed for vision problems related to cataracts or glaucoma. During an interview with Resident 54 on 11/5/24 at 3:56 p.m. in his room, Resident 54 stated he was legally blind (a statement that governments grant when you have severe vision loss) and had glaucoma and cataracts. Resident 54 stated he thought his vision was getting worse. Resident 54 stated that he requested to have his vision evaluated. Resident 54 stated that he had difficulty seeing with his current glasses. During an interview and concurrent review of Resident 54's electronic medical record (EMR) with the Minimum Data Set (MDS, a comprehensive care assessment tool) Coordinator (MDSC) on 11/6/24 at 1:25 p. m., the MDSC confirmed that Resident 54's admission care plan did not include diabetic cataracts or glaucoma. The MDSC also confirmed that there was no care plan for vision in Resident 54's EMR. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/8/24 at 12:30 p.m. with the Assistant Director of Nursing (ADON) 1, ADON 1 stated that each resident's care plan was developed upon admission and updated as needed. ADON 1 confirmed that Resident 54's care plan did not include glaucoma and diabetic cataracts upon admission. ADON 1 stated that the risk to Resident 54 was that he might not receive adequate care to meet his needs. ADON 1 confirmed that the facility policy was not followed. A review of a facility policy and procedure (P&P) titled, Care Plan, Comprehensive, dated December 2017, indicated, .It is the policy of this facility to develop, in conjunction with the resident and/or representative, the Comprehensive Resident Care Plan. The care plan is directed toward achieving and maintaining optimal status of health, functional ability, and quality of life. Baseline care plans are initiated within 48 hours of admission and completed no later than seven (7) days of the RAI (Resident Assessment Instrument, a comprehensive assessment ad care planning process used by the nursing home industry) .Purpose: To support and guide resident and Interdisciplinary Team (IDT, a team of professional staff who work together towards the goals of their clients) collaboration to achieve and maintain optimal resident health, function and quality of life . 43943 2. During a review of Resident 94's clinical record titled, Admission Record (a document that contains demographic information), indicated Resident 94's diagnosis included dementia (a general term for a decline in mental abilities that affects a person's daily life), hemiplegia and hemiparesis (inability to move one side of the body) following a stoke (oxygen deprivation to the brain for an amount of time causing brain damage), and hallucinations (seeing things that are not real). During a concurrent observation and interview with Resident 94 and Licensed Nurse (LN) 1, on 11/5/24 at 10:00 a.m., LN 1 verified Resident 94's call light was hanging off the right side of her bed and not in reach and the fall mat (a soft mat placed at the side of the bed to help cushion a fall) was pushed away (approximately 4 feet) from the right side of Resident 94's bed. LN 1 asked Resident 94 if she could reach her call light, and Resident 94 stated, no. LN 1 then handed Resident 94 her call light and prompted her to press the call light button. Resident 94 was unable to push the button due to weakness in her hands. LN 1 stated Resident 94 was a high risk for falls and should have had an adaptive call light (a call light that required the resident to tap on a pad instead of pushing a button) and the fall mat should have been pushed up close to the side of the bed. A review of Resident 94's clinical record titled, Fall Risk Assessment, dated 10/11/24, indicated Resident 94 was at high risk for falls (score of 50) related to a medical diagnosis (that contributes to falls) and that Resident 94 overestimated her ability to walk. During a review of Resident 94's clinical record titled, Section GG Functional Abilities - Admission (a section of a comprehensive assessment), dated 10/16/24, indicated Resident 94 was dependent on staff for eating, oral hygiene, toileting hygiene, shower/bath, upper and lower dressing, and rolling from side to side. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/06/24, at 2:30 p.m., with the Minimum Data Set Nurse (MDS - the nurse who codes the assessment that indicated Resident 96's physical abilities and interventions needed for care), Resident 94's clinical record titled, Care Plan, dated 10/14/24, was reviewed. MDS stated there was not a current fall care plan in place, but there should have been because Resident 94 was at high risk for falls. MDS stated the lack of a fall care plan placed Resident 94 at risk for injury. During a review of Resident 94's clinical record titled, Care Plan, dated 10/14/24, indicated Resident 94 took specific medications that placed her at a safety risk and potential injury. A review of the facility's Policy and Procedure (P&P) titled, Fall Prevention and Response, dated 8/23, indicated, . Each Resident will be assessed for fall risk factors and will receive care and services in accordance with individualized level of risk to minimize the likelihood of falls.Facility will assess each Resident's individual fall risk factors and implement comprehensive, resident centered fall prevention plans for each resident at risk for falls .A Licensed Nurse will initiate a .comprehensive care plan to address identified risk factors and initiate appropriate interventions to minimize risk and reduce injuries . During a concurrent interview and record review on 11/7/24, at 2:39 p.m., with the Director of Nursing (DON) and the Administrator (ADM), the facility's P&P titled, Care Plan, Comprehensive, dated 12/2017 was reviewed. The P&P indicated, . the care plan is directed toward achieving and maintaining optimal status of health, functional ability, and quality of life . The DON and ADM acknowledged the Fall Care Plan should have been started immediately after the fall risk assessment deemed Resident 94 of a high fall risk and stated the P&P was not followed.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 49823 Based on interview and record review the facility failed to assist 1 of 41 sampled residents (Resident 54) with obtaining vision services in a timely manner when the outside vision provider deemed Resident 54 ineligible to receive vision services through them and the facility did not follow-up and/or attempt to find another vision provider. This failure resulted in Resident 54 feeling frustrated about his vision and had the potential to negatively impact Resident 54's psychosocial well-being. Findings: A review of Resident 54's ADMISSION RECORD indicated Resident 54 was admitted to the facility in 2024 with diagnoses which included diabetic cataract (a clouding of the eye's lens that can lead to decreased vision and blindness), and glaucoma (a chronic eye disease that occurs when fluid builds up in the eye causing gradual loss of sight). During an interview with Resident 54 on 11/5/24 at 3:56 p.m. Resident 54 stated that he was legally blind (a statement that governments can grant you when you have severe vision loss) and had glaucoma and cataracts. Resident 54 stated that he felt that his vision was getting worse, and he had requested to have his vision evaluated two months ago. Resident 54 stated that he had not heard an update on his request to have his vision evaluated and that he had repeatedly asked Social Services to have his vision evaluated. Resident 54 stated he was frustrated that he had not received an update on his requests and he had difficulty seeing with his current glasses. A review of Resident 54's physician order, dated 5/31/24, indicated, .May have eye health & vision consultation with follow up treatment as indicated . During a concurrent interview and record review of Resident 54's electronic medical record (EMR) with the Social Services Assistant (SSA) on 11/6/24 at 1:20 p.m., in the Social Services Office, the SSA stated Resident 54 had medical insurance. The SSA stated Resident 54 requested to have his vision assessed by a physician and that Resident 54's insurance provider was contacted regarding the request. The SSA confirmed that a document in Resident 54's EMR, Advanced Eyecare, dated 9/23/24 indicated, ineligible. The SSA stated that she did not know who scanned the document into Resident 54's EMR, or what ineligible meant. The SSA stated that she was not sure if steps were taken to have Resident 54 screened by another vision provider. The SSA confirmed that Resident 54 needed to have his vision screened. During a concurrent interview and record review of Resident 54's EMR with the Social Services Director (SSD), on 11/6/24 at 4:50 p.m., the SSD confirmed Resident 54's Social Services Progress Note, dated 7/15/24, indicated Resident 54 was ineligible to be seen by the vision provider but they had not notified Resident 54. The SSD confirmed that a document in Resident 54's EMR, Advanced Eyecare, dated 9/23/24, indicated, ineligible. The SSD stated when she saw the document, she did not know what ineligible meant, so she called to schedule an appointment for vision screening with Resident 54's insurance provider. The SSD confirmed that there was no Social Services Progress Notes regarding a call for a vision referral documented in Resident 54's EMR in September 2024 or October 2024. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Assistant Director of Nursing (ADON) 1 on 11/8/24, at 12:30 p.m., ADON 1 stated that when residents verbalized there was a problem with their vision, the physician was called, and orders were given for an eye exam. ADON 1 stated that Social Services was notified. ADON 1 stated that the Resident and/or the Responsible Party (the person designated to direct the care of a loved one admitted into a skilled nursing facility) was notified that the vision exam was ordered. ADON 1 stated that Social Services worked to accommodate appointments and the notes from the exam were given to the nurses directly to review. ADON 1 confirmed that the facility process related to vision services was not followed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 50161 Based on observation, interview, and record review, the facility failed to ensure safe smoking practices, for eight sampled residents out of nineteen residents who smoked (Resident 22, Resident 38, Resident 49, Resident 53, Resident 61, Resident 112, Resident 118, and Resident 120) when: 1. Resident 38 was observed to have cigarettes and a lighter unsecured in his room, and Resident 38 was assessed and determined not to be an independent smoker; 2. Resident 49 stated she kept her cigarettes and lighter in her room unsecured, and she was observed in her room to be receiving continuous oxygen via nasal canula (NC, tubing that delivers oxygen into your nose), and was assessed and determined to not be an independent smoker; and, 3. Resident 53, Resident 120, Resident 118, Resident 112, Resident 22, and Resident 61 had their cigarettes and/or e-cigarette (a battery powered device that simulates tobacco smoking), and lighter on their person, unsecured in their room. These failures exposed the residents, staff, and visitors to be risks of burns, fire, and or explosion while in the facility, due to unsafe smoking practices. Findings: 1. Review of Resident 38's Smoking Safety Screen, dated 4/16/24, indicated, Resident 38 was High Risk for accidental injury; smoking related diseases and conditions .Supervised smoking only with smoking apron . Review of Resident 38's High Risk for Accidental Injury Care Plan, dated 4/16/24, indicated, .High Risk for accidental injury; smoking related diseases and conditions related to weakness .Interventions/Tasks . Observe/report unsafe smoking practices . Staff to retain cigarettes and lighter .date initiated 09/12/2024 . During a concurrent observation and interview on 11/5/24, at 10:43 a.m., Resident 38 was observed to be laying in his bed and on his bedside table was a pack of cigarettes and a lighter. Resident 38 stated he had been at the facility for three months and confirmed the cigarettes and lighter were his. Resident 38 stated he went to outside to smoke whenever he wanted to because if he went outside during the scheduled time from 10 a.m. to 11 a.m., he would not have time to eat his breakfast. During a concurrent observation and interview on 11/6/24, at 8:57 a.m., with Licensed Nurse (LN) 1 and Resident 38, in Resident 38's room, LN 1 confirmed Resident 38 had a pack of cigarettes and a lighter sitting on his bedside table. LN 1 stated Resident 38 goes out to smoke on the patio. LN 1 stated Resident 38 was a little forgetful due to him having a previous stroke. LN 1 stated he thought Resident 38 had a lockbox. It was observed there was a lockbox on Resident 38's table. Resident 38 stated he had never seen the lockbox before, and he did not have a key to the lockbox. Resident 38 stated he kept his extra cigarettes in the top drawer of his bedside cabinet. LN 1 confirmed there were extra packs of cigarettes in Resident 38's bedside table drawer. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/8/24, at 8:37 a.m., CNA 2 stated he normally helps Resident 38 get into his wheelchair, and then Resident 38 would take himself to the back patio, CNA 2 stated Resident 38 carries his cigarettes and his lighter with him. CNA 2 confirmed Resident 38 had cigarettes in an unlocked drawer in his side table. CNA 2 stated residents would go outside whenever they want to smoke, and he had not received any training regarding residents smoking. 2. Review of Resident 49's Smoking Safety Screen, dated 6/20/24, indicated, Resident 49 was High Risk for accidental injury; smoking related diseases and conditions . and must be supervised and wear a protective non-flammable cover when smoking. During a concurrent observation and interview on 11/7/24, at 9:15 a.m., with Resident 49, Resident 49 was observed in her room, sitting in her wheelchair, and wearing an oxygen nasal canula delivering oxygen via an oxygen condenser (portable oxygen concentrator is a medical device that helps deliver oxygen therapy to people who have low levels of oxygen in their blood). Resident 49 stated she had been living in the facility for five years and has worn oxygen for the last five years. Resident 49 stated she kept her cigarettes and lighter in her purse which was in her room. Resident 49 stated she kept her extra packs of cigarettes in her drawer. Resident 49 stated before yesterday no staff had ever mentioned the risk for her having her lighter and cigarettes in her room with her and stated her cigarettes and lighter had never been locked up in her room. 3. Review of Resident 53's Smoking Safety Screen, dated 9/11/24, indicated, Resident 53 was a safe smoker and may smoke independently, . non compliant with smoking schedule and wearing apron . and High Risk for accidental injury; smoking related diseases and conditions. During a concurrent observation and interview on 11/6/24, at 4:50 p.m., accompanied by CNA 1, Resident 53 was observed smoking outside on the patio, not wearing an apron. Resident 53 stated there was no supervision when she smoked. Resident 53 stated she did have a locked box in her room but did not have a key to the box so her cigarettes and lighter were not kept locked. Resident 53 stated she had one to two packs of cigarettes and one lighter with her in her room. Review of Resident 120's Smoking Safety Screen, dated 9/13/24, indicated, Resident 120 must be supervised . and wear a protective non-flammable cover (smoking apron) when .smoking . and was High Risk for accidental injury; smoking related diseases and conditions. During a concurrent observation and interview on 11/6/24, at 4:45 p.m., with Certified Nurse Assistant (CNA) 1 and Resident 120, CNA 1 accompanied Resident 120 to his room. Resident 120 was observed to have three and one half packs of cigarettes and three lighters, stored in a plastic bag, in an unlocked side table in his room. Resident 120 stated he got help from staff to get outside, and he does not wear a smoking apron. CNA 1 stated Resident 120 always kept his cigarettes and lighter with him. Review of Resident 22's Smoking Safety Screen, dated 5/14/24, indicated, Resident 22 is a High Risk for accidental injury, smoking related diseases and conditions, and required .Supervised smoking only with smoking apron . Review of Resident 61's Smoking Safety Screen, dated 9/23/24, indicated, Resident 61 is a safe smoker and may smoke independently, also .High Risk for accidental injury; smoking related diseases and conditions . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 112's Smoking Safety Screen, dated 4/16/24, indicated, Resident 112 is a safe smoker and may smoke independently. Review of Resident 118's Smoking Safety Screen, dated 4/25/24, indicated, Resident 118 is a safe smoker and may smoke independently, and a High Risk for accidental injury; smoking related diseases and conditions. During a concurrent interview and record review on 11/6/24, at 4:09 p.m. with the Activity Director (AD), the facility document titled, Smoking Residents, undated, indicated a total of 19 residents were identified as smoking in the facility. The AD acknowledged that she kept locked the smoking supplies for only 3 of the 19 residents, which did not include Resident 53, Resident 38, Resident 49, Resident 120, Resident 118, Resident 112, Resident 22, and Resident 61. She stated none of the lock boxes in the facility had key. During an interview on 11/6/24, at 9:16 a.m., LN 1 stated the if residents were to have a lighter in their room which was not secured, the risk to residents could be a fire hazard. LN 1 stated the lighter and cigarettes were out in the open and other residents or visitors could take the cigarettes and lighter. LN 1 stated resident's cigarettes and lighters should be secured in the locked box or be kept with the Activities Department. In an interview on 11/8/24, at 12:51 p.m., the Assistant Director of Nursing (ADON) 2 stated, regarding cigarettes and lighters not secured in a resident's room, the risk to the resident would be, for burning themselves, risk to other resident's if they were to find it, risk for fire and burns, risk for burns or fire for residents who have oxygen in their room, and for explosion and fire for self and other residents. The ADON 2 stated the expectation was to follow the facility's smoking policy. The ADON 2 stated residents with oxygen should never have a lighter in their room whether they are deemed independent smokers or not due to safety risks. Review of a facility policy and procedure titled SMOKING POLICY, revised 2/2018, indicated, .For those facilities that allow smoking, it is policy to monitor and evaluate residence for safety related to smoking. Individual facilities have specific smoking rules that are provided to residents and families at the time of admission. The IDT is responsible for evaluating safety risks and providing a safe designated smoking location . PURPOSE .To assess monitor and manage resident safety specific to smoking .PROCEDURE . The IDT evaluates cognitive ability, judgment, manual dexterity, and mobility, as well as the need for adoptive or safety equipment upon admission, with a significant change of condition/function, and annually for resident expressing a desire to smoke .Staff will control the distribution of smoking material (cigarette, cigars, tobacco, lighters). Residents assessed and deemed independent smokers may be provided a way to secure their own smoking materials in a locked drawer or container .For residents who have been determined unsafe when smoking and need supervised smoking, staff will provide appropriate supervision for .Use of adaptive equipment (smoking aprons etc.) . Disposal of cigarettes in appropriate receptacles . Prohibiting smoking in the presence of oxygen use .Residents are expected to not infringe upon the rights or safety of other residents and will smoke in designated areas only . Specific facility smoking schedules will be followed where applicable .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49823 Based on observation, interview, and record review, the facility failed to ensure medications were administered in accordance with professional standards of practice for two of forty-one sampled residents (Resident 111 and Resident 105) when: 1. Resident 111's medications, including controlled substances (a drug or chemical that is regulated by the government for its manufacture, possession, and use) were left at Resident 111's bedside; and 2. The facility did not ensure correct route of medication administration for Resident 105. These failures had the potential for Resident 111 not to receive his medication, and/or another resident to ingest medication not prescribed to them, and for Resident 105 to receive medications with an altered effect. Findings: 1. A review of Resident 111's ADMISSION RECORD indicated Resident 111 was admitted with diagnoses which included osteomyelitis right ankle and foot (infection of the bone), and diabetes mellitus (a chronic condition that affects the way the body processes blood sugar). A review of Resident 111's Physician Order Summary indicated there was no order that allowed Resident 111 to self-administer his medications. A review of Resident 111's Care Plan indicated there was no assessment that allowed Resident 111 to self-administer his medications. During an observation with Resident 111 on 11/5/24 at 10:10 a.m. in his room, a plastic cup with medications in pill form was left on the bedside table. Resident 111 stated these were his medications. During an interview with Licensed Nurse (LN) 6 at the medication cart on 11/5/24 at 10:17 a.m., LN 6 stated Resident 111 asked her to leave the medications at the bedside. LN 6 stated she was not supposed to leave the medications at the resident's bedside, and stated the risk was another resident could have taken the medications. LN 6 stated vitamin C (nutrition supplement), tramadol (opioid narcotic medication for pain), iron (nutritional supplement), magnesium (nutritional supplement), lactobacillus (helps with digestion), and vibegron (treatment for overactive bladder, a condition in which the bladder muscles contract uncontrollably and causes an urgent need to urinate) were the medications left at Resident 111's bedside. LN 6 stated she went back to Resident 111's room, and he took the medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Assistant Director of Nursing (ADON) 1 on 11/08/24 at 1:06 p.m., ADON 1 stated nurses should have stayed with the residents until the resident took their medications to ensure that the medications were swallowed by the resident. ADON 1 stated the risk was that staff were not sure if medications were taken by the resident, and it was a danger to the other residents. ADON 1 confirmed that the facility policy was not followed. A review of a facility policy and procedure (P&P) titled, 6.0 General Dose Preparation and Medication Administration, dated 12/1/07, indicated, .3. Dose Preparation: Facility should take all measures required by facility policy and applicable law, including, but not limited to the following .3.9 Facility staff should not leave medications or chemicals unattended .5. During medication administration, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: .5.5 Observe the resident's consumption of the medication(s) . 2. A review of Resident 105's ADMISSION RECORD, indicated Resident 105 was admitted to the facility in the Fall of 2022, with diagnoses which included gastrostomy (a surgical procedure that creates an opening in the abdomen that allows a feeding tube, G-Tube, to be inserted directly into the stomach). A review of Resident 105's Progress Notes, dated 7/25/24, indicated, .[physician name] made aware resident is on PO [by mouth] diet and med and well tolerated and clarified oral meds route of administration and noted . During a concurrent interview and medication pass observation, with licensed nurse (LN) 1, on 11/7/24, at 8 AM, LN 1 was observed passing the following medications, via G-tube route, to Resident 105: 1. Carvedilol (used to treat heart failure and high blood pressure) 3.125 mg (milligrams a unit of measure) 1 tablet PO, with an order date of 7/25/24, administered via G-Tube, after verbalizing the route ordered was PO; 2. Losartan (used to treat high blood pressure) 25 mg 0.5 tablet PO, with an order date of 7/25/24, administered via G-Tube, after verbalizing the route ordered was PO; 3. Jardiance (helps to control blood sugar levels in diabetes type 2) 25 mg 0.5 tablet PO, with an order date of 7/25/24, administered via G-Tube, after verbalizing the route was PO; 4. Multivitamin with minerals 1 tablet PO, with an order date of 7/25/24, administered via G-Tube, after verbalizing the route was PO; and, 5. Senna (medication to promote bowel movement) 8.6 mg 1 tablet PO, with an order date of 7/25/24, administered via G-Tube, after verbalizing the route was PO. A review of Resident 105's Order Summary Report, indicated the above medications were accurate and the orders indicated they should have been administered PO. A review of Resident 105's Medication Administration Report (MAR), dated 11/1/24 through 11/30/24, indicated the above medications were signed off as administered PO on 11/7/24. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LN 7, on 11/7/24, at 4 PM, LN 7 confirmed Resident 105 was the only resident he had receiving medications through a G-Tube. During an interview with LN 4, on 11/8/24, at 10:01 AM, LN 4 stated he gave Resident 105's medication via the G-Tube because Resident 105 had a G-tube. LN 4 stated if the medication was ordered PO he should administer the medications PO, and if the resident refused, he should inform the physician. A review of Resident 105's clinical document titled, [facility name] Fax Notification/Order Transmittal, dated 7/27/24, indicated, .Resident is no longer receiving G-Tube [gastrostomy] feeding. Normal PO [by mouth] intake. Can we change her medication orders to PO?. Document was signed, noted, and okayed by physician. During an interview with the Physician on 11/8/24, at 7:57 AM, the Physician stated he thought the medications should have been administered PO. The Physician explained he would expect the order to be followed if it was changed from G-tube to PO. The Physician further stated if the resident was eating by mouth, he would expect her medication would be administered PO. The Physician stated there were some medications that cannot be administered through the G-Tube, and it had to do with the form of the medication. During an interview with the Assistant Director of Nursing (ADON) 1, on 11/8/24, at 10:17 AM, ADON 1 stated the medications should be given PO, if that was what the order indicated. ADON 1 stated the nurses were not following physician orders. The ADON explained if the medication was extended release, it would not be able to be crushed and administered via the G-Tube, it would affect the efficacy of the medication. If the order was PO and there was a problem, the nurse should notify the physician. During an interview with the Pharmacist Consultant (PharmC), on 11/8/24, at 11:03 AM, the PharmC explained the medications should have been administered PO and she was not aware they were being administered via G-Tube. The PharmC explained the nurses should be following the physician orders. A review of the facility policy titled, 6.0 General Dose Preparation and Medication Administration, reviewed 1/1/13, indicated, .Prior to administration of medication, facility staff should take all measures required by facility policy and applicable laws, including, but not limited to the following .Verify each time a medication is administered that it is the correct medication, at the correct time, at the correct route .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 40583 Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than 5% (% or percentage is a fraction of a number out of 100) during medication administration. The facility had a total of five errors out of 28 opportunities, which resulted in a facility wide medication error rate of 17.8%. Medication observations were conducted over multiple days, at varied times, in random locations throughout the facility. The five medication errors were identified in one resident (Resident 105) out of six residents observed for medication administration observation when Resident 105's medications were administered via gastrostomy tube (G-Tube-a tube inserted directly into the stomach for nutrition and medication administration) when they were ordered to be administered by mouth (PO). This unsafe medication administration practice could result in medication errors, negatively affecting the health and well-being of Resident 105. Findings: During a concurrent interview and medication pass observation, with licensed nurse (LN) 1, on 11/7/24, at 8 AM, LN 1 was observed crushing medications for Resident 105. LN 1 verbalized the route was PO. LN 1 administered them to Resident 105 via G-tube route. The Medication Administration Record (MAR) indicated the following medications were to be administered PO: 1. Carvedilol (used to treat heart failure and high blood pressure) 3.125 mg (mg-milligrams a unit of measure) 1 tablet PO, with an order date of 7/25/24; 2. Losartan (used to treat high blood pressure) 25 mg 0.5 tablet PO, with an order date of 7/25/24; 3. Jardiance (helps to control blood sugar levels in diabetes type 2) 25 mg 0.5 tablet PO, with an order date of 7/25/24; 4. Multivitamin with minerals 1 tablet PO, with an order date of 7/25/24; and, 5. Senna (medication to promote bowel movement) 8.6 mg 1 tablet PO, with an order date of 7/25/24. The above medications were administered via G-Tube. During an interview with the Physician, on 11/8/24, at 7:57 AM, the Physician stated he thought the medications should have been administered PO. The Physician explained he would expect the order to be followed if it was changed from G-tube to PO. The Physician stated there were some medications that cannot be administered through the G-Tube and it had to do with the form of the medication. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Assistant Director of Nursing (ADON) 1, on 11/8/24, at 10:17 AM, the ADON stated the order indicated the medications should have been given PO, and stated the nurses were not following physician orders. The ADON explained if the medication was extended release, it would not be able to be crushed and administered via the G-Tube, it would affect the efficacy of the medication. If the order was PO and there was a problem with swallowing the medications, the nurse should notify the physician. During an interview with the Pharmacist Consultant (PharmC), on 11/8/24, at 11:03 AM, the PharmC explained the medications should have been administered PO and she was not aware they were being administered via G-Tube. The PharmC explained the nurses should be following the physician orders. A review of the facility policy titled, 6.0 General Dose Preparation and Medication Administration, reviewed 1/1/13, indicated, .Prior to administration of medication, facility staff should take all measures required by facility policy and applicable laws, including, but not limited to the following .Verify each time a medication is administered that it is the correct medication, at the correct time, at the correct route .

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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. 40583 Based on observation, interview and record review, the facility failed to ensure medications were stored in a clean and sanitary environment, when medications were found not to be in its bubble pack (a way to store single doses of medication). The unidentifiable medication was loose at the bottom of the medication cart drawer. This failure had the potential for medications to be unaccounted for, and increased the risk of medication error. Findings: During a concurrent observation and interview with licensed nurse (LN) 6, on 11/7/24, at 1:25 PM, a loose pill was observed at the bottom of the Station 2 Medication Cart. LN 6 stated she was not able to identify the pill. LN 6 explained the importance of ensuring there were no loose pills at the bottom of the medication cart drawer to ensure cleanliness and accountability. During an interview with the Assistant Director of Nursing (ADON) 1, on 11/8/24, at 12:29 PM, ADON 1 explained the importance of not having loose pills in the medication cart was a danger to the nurse and it was an infection control issue. A review of the facility pharmacy policy titled, 5.3 Storage and Expiration of Medications, Biologicals, Syringes, and Needles, revised 10/31/16, indicated, .Facility should ensure that the medications and biologicals for each resident are stored in the containers in which they were originally received .

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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. 47369 Based on observation, interview, and record review, the facility failed to prepare and serve foods in a consistent and appetizing manner when, 1. Resident 40 and Resident 120 were served food that was cold, and the test trays sampled on 11/7/24 were bland in flavor and not of an appetizing temperature; and 2. Recipes were not followed for 15 of 15 residents receiving pureed diets (food that have been ground to a soft, smooth consistency, like pudding) on 11/7/24. These failures had the potential to result in decreased meal intake for the 127 residents receiving meals in the facility, which could lead to weight loss and malnutrition. Findings: 1. A review of Resident 40's ADMISSION RECORD, indicated he was admitted to the facility in the fall of 2024. A review of Resident 120's ADMISSION RECORD, indicated he was admitted to the facility in the spring of 2023. During an interview on 11/5/24, at 12:28 PM, Resident 40 stated the food was always served cold. During an interview on 11/6/24, at 8:29 AM, Resident 120 stated the food was always cold. During a concurrent observation and interview on 11/7/24, at 1:38 PM, a pureed and regular texture test tray were sampled with the Registered Dietitian (RD). The RD confirmed the pureed beef tasted bland. The RD further confirmed the rice and potatoes tasted bland and he would have added salt and pepper. The RD confirmed the food temperatures could be warmer. The RD stated it was his expectation residents would be served meals that were palatable (pleasant to taste), and that food temperatures were an individualized preference, but an important part of the palatability. The RD further stated there was a risk to the residents of not consuming their meals if they did not find them palatable. 2. During an observation on 11/7/24, at 10:40 AM, dietary assistant (DA) 2 was observed preparing pureed carrots. DA 2 added cooked carrots to the blender and turned it on. DA 2 stated she did not add liquids or anything to her pureed foods. During an observation on 11/7/24, at 11:40 AM, the cook was observed preparing the pureed meat portion of the meal. The meat used for the pureed diets was frozen, prepackaged, hamburger patties. The cook removed the patties from the oven and pureed them in the blender. During an observation on 11/7/24, at 11:42 AM, the cook placed a 2.5 quart pan of water on the steam table and poured breadcrumbs into it from a package. The dietary manager (DM) pureed slices of bread in the blender and added them to the pan with the breadcrumbs. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a facility recipe titled, PARSLIED CARROTS .PU [puree], indicated, .PREPARE ACCORDING TO REGULAR RECIPE .FOOD THICKENER BULK .PROCESS UNTIL SMOOTH ADDING 1/2 tbsp FOOD THICKENER PER SERVING .AMOUNT OF THICKENER REQUIRED MAY VARY RELATIVE TO LIQUID CONTENT OF COOKED VEGETABLE. FOR BEST RESULTS, ALTERNATE ADDING THICKENER WITH PROCESSING . A review of a facility recipe titled, HAMBURGER STEAK . indicated the following ingredients: ground beef, whole liquid egg, 2% milk, breadcrumbs, chopped onion, salt and black pepper. The recipe indicated, .FOR GROUND OR CHOPPED MENU ITEMS, GRIND TO APPROPRIATE CONSISTENCY . A review of a facility recipe titled, WHEAT BREAD . indicated, .10 servings .WHEAT BREAD 10 - 1 SLICE . WATER OR JUICE 1 1/4 Cup .FOOD THICKENER BULK 2 Tablespoon 1 1/2 teaspoon . PREPARE SLURRY AND PROCESS UNTIL SMOOTH ADDING 1 OZ. SLURRY PER PORTION .FOR BEST RESULTS, ALTERNATE ADDING THICKENER WITH PROCESSING .NUTRITIONAL ANALYSIS BASED ON USING WATER IN THE SLURRY . During an interview on 11/7/24, at 3:02 PM the Registered Dietitian (RD) stated the residents receiving pureed diets should receive the same foods as all the other residents. The RD further stated if residents received frozen foods instead of facility prepared foods they may not be as palatable and there could be a decline in a resident's meal intake. The RD stated it was his expectation that all residents would be provided the same menu items. The RD stated when foods were pureed, the recipes should be followed and a stock or slurry should be added to ensure proper consistency, proper ingredient use, and for taste. The RD further stated the cook should taste the prepared food to ensure proper seasoning. A review of a facility policy and procedure (P&P) titled, Recipes, dated 2/09, indicated, PURPOSE .Ensure consistent food and dining quality and ease of preparation .It is the policy of this facility to utilize standardized recipes in the preparation of foods . A review of a facility P&P titled, RESIDENT FOOD ACCEPTABILITY, dated 2/09, indicated, .Resident's acceptance of the menu and food is monitored routinely .All food and dining services staff and nursing staff are responsible for monitoring resident meal satisfaction .When noting individual or group dissatisfaction with any aspect of meal preparation or service, the Food and Dining Services Manager initiates action to resolve the issue that has been identified .

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 47369 Based on observation, interview, and record review, the facility failed to ensure food preferences were honored for Resident 28 and Resident 101 during lunch on 11/7/24, when Resident 28's meal tray was prepared with carrots and ground beef and Resident 101 did not receive a protein portion on her meal tray. These failures had the potential to result in unintended weight loss and other adverse health effects for Resident 28 and Resident 101. Findings: A review of Resident 28's ADMISSION RECORD, indicated, she was admitted to the facility in the fall of 2022. A review of Resident 28's care plan, revised on 8/16/2024 indicated, .Altered nutrition and hydration (Risk) . Diet as Ordered .Honor food/fluid preferences . A review of Resident 101's ADMISSION RECORD, indicated she was admitted to the facility in the summer of 2022. A review of Resident 101's care plan, revised on 11/6/24, indicated, Altered nutrition and hydration (Risk) . 11-2-2024: Significant weight loss: (5.1%) over ~1 month . Diet as ordered .Honor food/fluid preferences . A review of the lunch menu for 11/7/24 indicated, .HAMBURGER STEAK W/ [with] GRAVY .STEAMED RICE .PARSLIED CARROTS .WHEAT BREAD .CINNAMON APPLES . During a tray line observation and record review on 11/7/24, at 12 PM, Resident 28's meal tray was prepared with a hamburger steak and carrots. Resident 28's tray card indicated, .Dislikes .CARROTS .HAMBURGUER [sic] . Resident 101's tray was prepared with a serving of bread and mashed potatoes; no meat portion was added to the tray. Resident 101's tray card indicated, .PUREED [foods that have been ground to a soft, smooth consistency, like pudding] .Dislikes .BEEF .PORK . During an interview on 11/7/24, at 3:02 PM, the Registered Dietitian (RD) stated resident's dietary preferences were assessed on admission and quarterly to ensure they were honored. The RD further stated audits were performed to ensure residents preferences were being followed and to monitor for weight loss. The RD confirmed dietary preferences should have been followed for resident 28. The RD further confirmed Resident 101 should have been provided chicken on her meal tray due to her dislikes of beef and pork. The RD stated Resident 101 needed protein to prevent muscle loss. A review of the lunch time menu for 11/8/24, indicated, .ROAST PORK W/ ROSEMARY SAUCE .WHITE BEANS .SEASONED ZUCCHINI .WHEAT ROLL .CHILLED PEACHES . (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During on observation on 11/8/24, at 11:48 AM, in the Seaside dining room, Resident 101 was observed consuming her meal. Resident 101's plate contained two pureed food items, one item was dark green, and the other was tan colored. A certified nurse assistant who was passing trays stated Resident 101's tray held mashed potatoes and a green veggie. During an observation and interview on 11/8/24, at 12:09 PM, the RD stated residents should receive a protein, starch, and vegetable on their meal trays. The RD reviewed a picture of Resident 101's lunch tray and stated he could not identify the tan food item on her plate. The RD stated it could be pork or wheat bread or something else. The RD confirmed Resident 101 potentially did not receive a protein portion on her tray or she may have received a disliked item on her tray. A review of a facility policy and procedure titled, RESIDENT FOOD PREFERENCES, dated, 11/16, indicated, .PURPOSE .satisfy resident's tastes and appetites by determining and providing their food preferences at meals .All food and dining services staff will be made aware of all preferences and food allergies. The food and dining services staff will avoid serving products that contribute to food allergies and make every attempt to meet the resident's food preferences .For residents who choose not to eat food that is initially served or who request a different meal, will have appealing options of similar nutritive value .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47369 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage practices for a total of 127 residents receiving food from the kitchen when: 1. Food items available for use in the dry storage area, were found in an opened and unsealed container and/or past their use by or best by dates; 2. Vegetables available for use in the walk-in refrigerator were wilted, decomposing, and moldy, and containers of sour cream were past their best by dates; 3. Freezer #2 contained ice buildup on all four walls; and, 4. The dishwasher water temperature was not within range. These failures had the potential to expose the 127 residents receiving food from the kitchen to expired, contaminated foods, and placed these residents at risk of food borne illness (an illness/infection caused by consuming contaminated food). Findings: 1. During a concurrent observation and interview on [DATE], at 8:21 AM, during the initial kitchen tour the following items were observed: a. an opened, unsealed box cream of wheat was on a shelf available for use. The Dietary Manager Assistant (DMA) stated the box should have been placed in a Ziploc bag after it was opened to reduce the risk of pests and cross contamination. b. Four bags of grits with a best by date of [DATE] were observed on the shelf next to the cream of wheat. c. A container of cooking [NAME] had an opened date of [DATE], a use by date of [DATE], and a best by date of [DATE]. d. An opened container of ground thyme had a best by date of [DATE], an opened container of poultry seasoning had an opened date of [DATE], a use by date of [DATE] and a best by date of [DATE]. An opened container of poultry seasoning had an opened date of [DATE], a use by date of [DATE], and an expiration date of [DATE], an opened container of ground ginger had no opened date, and a best by date of [DATE]. The DMA confirmed the items past their used by dates should not be on the shelves available for use. 2. During a concurrent observation and interview on [DATE], at 8:50 AM, in the walk-in refrigerator the following items were observed: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a. One bag of wilted, moist, cilantro with a delivery date of [DATE]. A box containing bags of wilted green cabbage with a received date of [DATE], and a use by date of [DATE]. A clear plastic bag of wilted spring mix salad with a received date of [DATE], and a tomato growing a white and black substance. The DMA stated once received, vegetables where good for one week. b. On a top shelf in the walk-in refrigerator four containers of sour cream were observed with a best by date of [DATE] and two containers of sour cream were observed with best by dates of [DATE]. The DMA confirmed the items should not be available for use. 3. During a concurrent observation and interview on [DATE], at 8:46 AM, the chest freezer labeled Freezer #2 was observed with ice buildup on all four interior walls. The DMA stated the ice should not be there. During an interview on [DATE], at 3:02 PM, the Registered Dietitian (RD) stated opened, unsealed foods should not be available for use. The RD further stated all food items should be dated when opened and disposed of by their use by dates. The RD stated expired food items could lack palatability (pleasant taste) and should not be used. The RD further stated the ice buildup in freezer #2 signified that it may have been above the temperature range at some point in time. 4. During a concurrent observation and interview on [DATE], at 9:41 AM, dietary assistant (DA) 1 was putting dishes in the dishwasher. DA 1 stated the temperature gauge indicate the water temperature was 118 degrees Fahrenheit (F) and it should be 120 F . DA 1 stated after he ran it a few times the temperature would come up. During an observation and interview on [DATE], at 2:42 PM, DA 1 was observed using the dishwasher. DA 1 stated the temperature gauge read 95 F and it went up and down. DA 1 stated the water should be at 120 degrees to kill bacteria and sanitize the dishes. Three racks of plate covers, and two racks of cups were on the counter after having recently been washed in the dishwasher. During an interview on [DATE], at 3:02 PM, the RD stated the dishwasher in use was a low temperature dishwasher and should maintain a temperature of 120 F when in use. The RD further stated if the dishwasher temperature went below 120 F , the maintenance director and the RD should be notified. The RD stated there was a risk to the residents of food borne illnesses if the correct temperature was not maintained. A review of a facility policy and procedure (P&P) titled, FOOD SAFETY IN RECEIVING AND STORAGE, dated ,d+[DATE], indicated, Food is received and stored by methods to minimize contamination and bacterial growth . Expiration dates and use- by dates will be checked to assure the dates are within acceptable parameters .opened packages will be resealed tightly to prevent contamination . A review of a facility P&P titled DISH MACHINE TEMPERATURES, dated ,d+[DATE], indicated, .To ensure proper sanitation of dishes, glassware and flatware .The temperature for washing and sanitizing dishware in the low temperature dish machines should be ,d+[DATE] degrees F .

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. 51285 Based on observation, interview, and record review, the facility failed to ensure 1 of 41 sampled residents (Resident 94) received rehabilitation services when Resident 94 was admitted to the facility and an order for Physical Therapy (PT; treatment that helps you improve how your body performs physical movements) and Occupational Therapy (OT; helps you improve your ability to perform daily tasks like getting dressed) was not initiated as indicated in Resident 94's hospital discharge summary. This failure had the potential to result in a decline in physical function for Resident 94. Findings: Review of Resident 94's ADMISSION RECORD, indicated Resident 94 was admitted to the facility in October 2024, with diagnoses which included hemiplegia (partial or total loss of muscle function on one side of the body) and hemiparesis (one-sided weakness but without complete loss of muscle function) affecting the left dominant side. During a concurrent interview and record review on 11/6/24 at 2:05 p.m., the Director of Rehab (DOR) confirmed Resident 94 had never been assessed for PT and OT and there was not an order from the Medical Director (MD) for physical and occupational therapy evaluation. The DOR confirmed that Resident 94's section GG (describes functional abilities) on the Minimum Data Set (MDS; an assessment tool), initiated 10/16/24, indicated, . [Resident 94] depend on staff for needs .due to unable to use left dominant side . The DOR confirmed Resident 94's Emergency Department Discharge Notes, dated 10/11/24, indicated, . [Resident 94] needs skilled PT, OT . During a concurrent observation and interview on 11/6/24, at 3:04 p.m., with the DOR, the DOR confirmed Resident 94 was unable to open her left hand and her right hand was weak. The DOR stated Resident 94 could benefit from Restorative Nurse Aide (RNA; can help ensure that each resident will maintain his or her maximum functional capacity) services and a PT and OT evaluation. The DOR stated Resident 94 could use a carrot roll to keep her left hand open so she could maintain her current level of function. During an interview on 11/7/24 at 11 a.m., with Licensed Nurse (LN) 8, LN 8 stated licensed nurses read the progress notes from the hospital discharge summary and verified the orders with the Medical Director (MD). LN 8 stated when there was no PT and/or OT orders in the Electronic Health Record (EHR) the doctor would be called to clarify if an order was needed. During an interview on 11/7/24 at 11:18 a.m., the Assistant Director of Nursing (ADON) 1 stated it was the ADON's responsibility to review hospital orders for new admissions and the Admit Nurse carried out the orders. ADON 1 stated the following day the clinical team would review admission orders and double check progress notes to ensure no orders were missed. During an interview on 11/7/24 at 12:30 p.m., the Medical Director (MD) stated her expectation was for Resident 94 to have been given PT, OT, or RNA services. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/7/24 at 1:19 p.m., with the Director of Nursing (DON), the job description for the Assistant Director of Nursing (ADON) was reviewed. The DON stated if any resident did not qualify for PT/OT and/or RNA services, there should have been a note entered into the residents Electronic Health Record (EHR). The DON confirmed the ADON JOB DESCRIPTION/ PERFORMANCE EVALUATION, revised 11/13/17, indicated that the ADON, .Review admission and D/C [discharge] charts in an appropriate time-frame to ensure compliance with clinical practice and documentation standards . collaborate with admissions staff and nursing staff on admission process . provide admissions and discharge support as identified by DON .

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 40583 Based on interview and record review, the facility failed to ensure coordination of care with hospice services (provides symptom management at the end of life) for three of fifteen residents (Resident 139, Resident 121, and Resident 25) receiving hospice services in the facility, when the facility failed to ensure Hospice Provider's Visit Notes were received and reviewed by the facility staff. These failures had the potential for Resident 139, Resident 121, and Resident 25, care needs to go unrecognized, negatively impacting their health and well-being. Findings: a. A review of Resident 139's Admission Record, indicated Resident 139 was admitted to the facility in Fall 2024, with diagnoses which included depression, anxiety disorder, and repeated falls. During a review of Hospice 1's binder (contains information to coordinate care with the facility, such as hospice nursing notes and hospice physician orders), the section for Resident 139 indicated there were no hospice visit notes available in the binder from 9/7/24 to 9/20/24 (13 days), and from 9/20/24 to 10/30/24 (40 days). During an interview with Hospice 1's Administrator (Hospice ADM) for Resident 139, on 11/7/24, at 3:15 PM, the Hospice ADM stated the Hospice care providers wrote notes for their visits to the residents. The Hospice ADM explained the Hospice care provider's notes were in their Electronic Medical Record (EMR) and were left or sent to the facility. The Hospice ADM stated the importance of leaving the notes was to ensure coordination of care with the facility by having interdisciplinary communication and keeping the facility informed of the plan of care. During a record review with the Medical Records Director (MRD), on 11/7/24, at 3:20 PM, the MRD confirmed they had not received any e-mails from the Hospice with the Hospice Nursing Notes. During an interview with the Assistant Director of Nursing (ADON) 1, on 11/7/24, at 3:24 PM, the ADON 1 stated the Hospice 1's care provider notes should be left with the facility the week of the visit. ADON 1 further explained the facility needed the hospice nursing notes to follow-up and determine the outcome of the visit. ADON 1 explained the importance of coordination of care with hospice was to better take care of the resident and follow any orders that need to be followed through on, and that was how they communicated. b. A review of Resident 121's Admission Record, indicated Resident 121 was admitted to the facility in Summer 2022, with diagnoses which included depression and anxiety disorder. During a review of Hospice 2's Binder for Resident 121, there were no hospice care provider nursing notes for August 2024, September 2024, and October 2024 in Resident 121's hospice binder. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Hospice 2's Hospice Clinical Director (HCD), on 11/7/24, at 4:31 PM, the HCD stated the hospice care provider nursing notes were sent to the facility every week. The HCD explained it was her expectation the hospice care provider nursing notes be sent every week to ensure collaboration of care and for the facility to review the plan of care and medication lists from the hospice team. A review of e-mails sent by Hospice 2 to the facility showed weekly e-mails of Hospice 2's communication with the facility containing the Hospice 2's care provider nursing notes. During an interview with ADON 1, on 11/7/24, at 4:35 PM, ADON 1 confirmed the e-mails had been sent for August 2024, September 2024, and October 2024, but had not been opened and reviewed by the facility. A review of the Hospice 2's Contract, undated, indicated, .Joint Responsibilities/Mutual Promises: Communication: The hospice and the facility will establish a method to ensure that the needs patients [residents] are addressed and met 24 hours a day. This communication will be documented in the patient's medical record by both parties .both providers will develop mutually agreed upon policies and procedures which address the following: .How all needed services, medical supplies, DME [durable medical equipment] and drugs and biological necessary for the palliation and management of pain and symptoms associated with the terminal illness and related conditions will be made available to the patient 24 hours a day, 7 days a week . c. A review of Resident 25's Admission Record, indicated Resident 25 was admitted to the facility in Fall 2023, with diagnoses which included anxiety disorder and bipolar disorder (a mental illness that causes extreme mood swings, or shifts in mood, energy, and activity levels). A review of Resident 25's clinical record indicated Resident 25 was admitted to Hospice 3 in September 2023. During a review of Hospice 3's Binder for Resident 25, there were no hospice care provider nursing notes for July 2024, August 2024, September 2024, and October 2024. During an interview with ADON 1, on 11/7/24, at 3:50 PM, ADON 1 acknowledged there were no hospice care provider nursing notes for July 2024, August 2024, September 2024, and October 2024. During a follow-up interview with ADON 1, on 11/7/24, at 4:21 PM, ADON 1 acknowledged the hospice care provider nursing notes for July 2024, August 2024, and September 2024 were in e-mails that had been sent to the facility and had not been opened or reviewed yet. During an interview with the Director of Nursing (DON), on 11/7/24, at 4:40 PM, the DON stated his expectation was for the hospice care provider nursing notes to be sent to the facility and placed in the resident's hospice binder at least weekly. The DON explained it was important because facility nursing staff needed to have access to the resident's clinical information as the information facilitates care of the residents on hospice.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49823 Based on observation, interview, and record review, the facility failed to maintain its Infection Prevention and Control Program for a census of 137, when: 1. Isolation precautions (measures taken to prevent spread of infection) were not implemented timely for Resident 68; and, 2. The facility did not ensure glucometers were cleaned and sanitized. These failures had the potential for cross contamination, negatively impacting the health and well-being of residents residing in the facility. Findings: 1a. A review of Resident 68's Admission Record indicated Resident 68 was admitted to the facility in 2020 with diagnoses which included diabetes mellitus (a chronic condition that affects the way the body processes blood sugar) and end stage renal disease (failure of the kidneys to function normally). A review of Resident 68's Physician Order Summary, dated 10/9/24, indicated, . Loperamide Hydrochloride (medication given for diarrhea) 2 milligrams (mg, unit of measure) give two tablets by mouth one time only for after the first loose stool for one day, Loperamide Hydrochloride 2 mg one tablet by mouth every six hours as needed after each subsequent loose stool do not take more than four tablets in 24 hours . A review of Resident 68's Care Plan updated 11/4/24, indicated Resident 68 had loose stools (diarrhea; frequent liquid bowel movements with stomach cramping) after dialysis (a type of treatment that helps your body remove extra fluids and waste products from your blood when your kidneys are not able to). During an observation on 11/5/24 at 10:10 a.m., Resident 68 was sleeping in her room. No isolation precaution sign was observed on Resident 68's room door. No personal protective equipment (PPE, gowns, gloves, masks, eye protection or respirators used to prevent the spread of germs) was observed outside of Resident 68's room. During an observation on 11/6/24 at 11 a.m., Resident 68's room door was open, but Resident 68 was not in her room. No Contact isolation Precaution (measures taken to prevent the spread of germs that cause infections spread by direct or indirect contact with the resident or the resident's environment) sign was seen on Resident 68's room door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 68's Lab Results Report, dated 11/6/24, indicated that a stool specimen (obtaining a sample of the resident's diarrhea and sending it to the lab for testing) was sent on 11/5/24 to test it for Clostridium difficile (C. difficile, a highly contagious [able to be easily spread from one person to another by contact] germ that affects the intestines, causes diarrhea, and is life-threatening). Resident 68's Lab Results Report indicated the stool sample tested positive for C. difficile and the positive results were reported to the facility on [DATE] at 3:36 p.m. A review of Resident 68's Progress Notes, dated 11/6/24 at 11:05 p.m. indicated Resident 68 had loose stools. A review of Resident 68's Progress Notes, dated 11/8/24 at 7:26 a.m. indicated Resident 68 was placed on Contact Isolation Precautions by the facility Infection Preventionist (IP). During an observation and interview with the IP outside of Resident 68's room on 11/8/24 at 8:45 a.m., the IP stated Resident 68 was on contact isolation precautions. There was a Contact isolation sign and PPE outside Resident 68's room. During an interview by phone with Licensed Nurse (LN) 8 on 11/8/24 at 8:51 a.m. at the dialysis facility, LN 8 stated Resident 68 called the facility on 11/7/24 and informed them that she had C. difficile. LN 8 stated the facility did not call or notify them Resident 68 had C. difficile. During an interview and concurrent record review of Resident 68's electronic medical record (EMR) with the IP on 11/8/24 at 9:10 a.m., the IP stated she was informed of Resident 68's onset of loose stools on 11/5/24. The IP confirmed staff documented loose stools in Resident 68's EMR on 11/4/24, 11/5/24, and 11/6/24. The IP acknowledged a Progress Note in Resident 68's EMR dated 11/8/24 at 7:26 a.m., indicated Resident 68 was placed on Contact isolation precautions. The IP stated staff needed to place Resident 68 on contact isolation precautions on 11/4/24 when symptoms of loose stools began. The IP stated the facility was responsible for informing the dialysis clinic Resident 68 had tested positive for C. difficile. The IP stated licensed staff received education on when to start contact isolation precautions for onset of symptoms, until an infection was ruled out. The IP stated the risk of not starting contact isolation precautions on 11/4/24 was a potential spread of the infection to others in the facility. During an interview with Assistant Director of Nursing (ADON) 1 on 11/8/24 at 12:30 p.m., ADON 1 stated if a resident had loose stools, the physician was called, and orders for follow up were received, the resident was then placed on contact isolation pending results of testing. ADON 1 stated the IP would be notified, and the IP followed through on proper labs as ordered. A review of a facility policy and procedure (P&P) titled, Infection Prevention Manual for Long Term Care: Fact Sheet Clostridium Difficile, dated 2012, indicated .Precautions: Contact Precautions while having diarrhea . A review of a facility P&P titled, Hemodialysis, dated 12/2022, indicated, .Compliance Guidelines .3. The facility will monitor for and identify changes in the resident's behavior that may impact the safe administration of dialysis before and after treatment and will inform the attending practitioner and dialysis facility of the changes . (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an online document published by the Centers for Disease Control and Prevention (CDC) titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-Resistant Organisms (MDROs), last reviewed dated 7/12/22, indicated, .The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions (a type of transmission-based precaution intended to prevent the spread of MDROs and other germs that cause infections that are spread by direct or indirect contact with the resident or the resident's environment) are implemented .Post clear signage on the door or wall outside of the resident room indicating the type of Precautions and required PPE (e.g., gown and gloves) . 40583 2. During a concurrent interview and medication pass observation with licensed nurse (LN) 3, on 11/7/24, at 12:13 PM, LN 3 was observed cleaning the glucometer (analyzes blood to give a blood sugar number) after acquiring a blood sugar from a resident. LN 3 used a disinfectant wipe, wiping the glucometer and set the glucometer down to dry. LN 3 explained the contact time (time the disinfectant is wet) was 2 minutes. The contact time between the glucometer and disinfectant wipe was less than 10 seconds. During a concurrent interview and observation with LN 5, on 11/7/24, at 12:30 PM, LN 5 was observed cleaning the glucometer. LN 5 did not sanitize the glucometer. LN 5 explained she cleans the glucometer and then lets it air dry. During an interview with the Infection Preventionist (IP), on 11/7/24, at 1:01 PM, the IP explained the facility follows manufacturers guideline to clean and disinfect the glucometer. The IP explained cleaning the glucometer means to remove any dirt and debris. The IP further explained disinfecting the glucometer requires the chemical on the sanitizing wipe to sit for the allotted time to kill organisms that may be on the glucometer and the glucometer needs to be visibly wet for two minutes. The IP stated the importance of ensuring the glucometer was clean and disinfected was to prevent cross-contamination from bloodborne pathogens from one resident to another. A review of the facility procedure titled, Blood Sugar Monitoring, dated 2006, indicated, .Follow manufacturer's directions for use and care of the equipment . A review of a facility supplied document, untitled and undated, indicated, .Cleaning and disinfecting can be completed by using a .disinfectant .wipe .use one wipe to clean and a second wipe to disinfect . A review of the manufacturer's guidelines for the [brand name] sanitizing wipes used by the facility, dated 2023, indicated, Some organisms are removed from the surface by thoroughly wiping the surface with the wipe. Most remaining organisms are killed within two (2) minutes by exposure to the liquid in the wipe .