STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555520	A. Building B. Wing	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leisure Court Nursing Center	1135 Leisure Court Anaheim, CA 92801

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50967 Based on observation, interview, medical record review, and facility P&P review, the facility failed to assess if it was safe for one nonsampled resident (Resident 56) to self-administer the medications. * The facility failed to assess and develop a plan of care to address the self-administration of the medications when Resident 56 had a bottle of Flax Seed Oil (supplement) and Omegas + Tumeric (supplement) at the bedside. This failure had the potential for Resident 56 to administer the medications inaccurately and negatively affect the Resident 56's well-being. Findings: Review of the facility's P&P titled Medication Self-Administration dated 1/2017 showed the following: - Residents have the right to self-administer medications if the interdisciplinary team (IDT), determines that this practice is clinically appropriate; - On admission or shortly thereafter, each resident will be assessed to determine if they want to self-administer their medications; - It is the responsibility of the IDT to determine if its is safe for the resident to self-administer drugs before the resident may exercise that right. The IDT must determine whether the resident or the nursing staff will be responsible for storage and documentation of the administration of the medications, as well as the location where the medications will be administered. These determinations should appear on the resident's comprehensive plan of care; and - The determination of whether it is safe for the resident to self-administer medications should be completed within seven days of the completion of the resident's comprehensive assessment. On 1/21/25 at 1007 hours, a concurrent observation and interview was conducted with Resident 56. A bottle of Flax Seed Oil and Omegas + Tumeric were observed at Resident 56's bedside. Resident 56 stated she had taken one capsule of Flax Seed and one capsule of Omegas with Tumeric medications twice a day as her supplements. Resident 56 stated she had been self-administering the supplements since she was admitted to the facility. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident 56 was initiated on 1/22/25. Resident 56 was admitted to the facility on [DATE]. Review of Resident 56's H&P examination dated 8/9/24, showed Resident 56 had the capacity to understand and make decisions. Review of Resident 56's MDS dated [DATE], showed Resident 56's BIMS score was 15 (cognitively intact). Review of Resident 56's Order Summary Report dated 12/31/24, failed to show a physician's order for the Flax Seed Oil one capsule and Omegas + Tumeric one capsule twice a day and to allow Resident 56 to self-administer the medications. Review of Resident 56's Plan of Care failed to show a care plan problem was developed to address Resident 56's self-administration of the Flax Seed Oil and Omega + Tumeric medications. On 1/21/23 at 1517 hours, a concurrent observation and interview for Resident 56 was conducted with LVN 4. LVN 4 verified Resident 56 had a bottle of Flax Seed Oil and Omegas + Tumeric at the bedside. LVN 4 verified there was no physician's order for the use of the medications, and Resident 56 should not have the medications at the bedside. On 1/23/25 at 1457 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated any resident who requested to self-administer medications should be assessed by the MDS nurse then approved by the physician. The DON verified Resident 56 had no physician's order, assessment, and care plan problem addressing Resident 56's self-administration of the medications. On 1/27/25 1400 at hours, an interview was conducted with the DON and Administrator. The DON and Administrator were informed and acknowledged the above findings.

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 37726 Based on observation and interview, the facility failed to maintain a homelike environment for one of 24 final sampled residents (Resident 72) and one nonsampled resident (Resident 4). * Resident 72 resided in Room A and Resident 4 resided in Room B. Rooms A and B were observed with scratches and unpainted areas on the walls, adjacent to the residents' bed. This failure had the potential to negatively impact the residents' quality of life. Findings: 1. On 1/22/25 at 1211 hours, an observation and concurrent interview was conducted with Resident 72. Resident 72 was observed lying in her bed in Room A. Room A was observed with scratches and unpainted areas on the wall adjacent to Resident 72's bed. Resident 72 stated having the wall repaired and painted would be nice. 2. On 1/22/25 at 1217 hours, an observation and concurrent interview was conducted with Resident 4. Resident 4 was observed lying in her bed watching television, in Room B. Room B was observed with scratches and unpainted areas on the wall adjacent to Resident 4's bed. Resident 4 stated she spent most of her time in her room and would like the wall to be repaired. On 1/27/25 at 1430 hours, an interview was conducted with the Administrator. The Administrator was informed of the findings.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51920 Based on interview, medical record review, and facility P&P review, the facility failed to provide a notice of transfer/discharge to the Ombudsman for one of two sampled residents (Resident 109) reviewed for closed records. This failure posed the risk for Resident 109 and Resident 109's representative not being aware of their appeal rights and potentially jeopardizing the appeal process in the event Resident 109 and/or Resident 109's representative felt the facility-initiated transfer or discharge from the facility was inappropriate or involuntary. Findings: Review of the facility's P&P titled Discharge Process revised 1/2017 showed the facility will send a copy of the notice of transfer or discharge to a representative of the Office of the State Long-Term Care Ombudsman and record the reasons for the transfer or discharge in the resident's medical record. On 1/23/25 at 0947 hours, a closed medical record review was initiated for Resident 109. Resident 109 was admitted to the facility on [DATE], and discharged [DATE]. On 1/23/25 at 0959 hours, an interview was conducted with the Ombudsman. The Ombudsman stated she could not remember if she received the notice of discharge for Resident 109 but stated she would verify and call the survey team. On 1/23/25 at 1220 hours, the Ombudsman called and verified she did not receive the notification of discharge for Resident 109. On 1/23/25 at 1304 hours, a concurrent interview and closed medical record review was conducted with the SSD. Review of Resident 109's Physician Discharge Summary dated 11/14/24, showed the resident's welfare and needs could not be met in the facility. The SSD stated Resident 109 was only supposed to be there short term for respite care but was discharged after one day due to her aggressive and combative behaviors. The SSD verified the notification of discharge was to be provided to the responsible party, Ombudsman, and in the case of Resident 109, the VA hospital. The SSD was unable to locate the notice of transfer/discharge in Resident 109's medical record. On 1/23/25 at 1332 hours, a concurrent interview and closed medical record review was conducted with RN 2. RN 2 verified she was in charge of notifying the Ombudsman of discharges. RN 2 stated she tried to fax the notice of discharge to the Ombudsman the same day of the resident's discharge. RN 2 was unable to locate the notice of transfer/discharge in Resident 109's medical record.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on interview and medical record review, the facility failed to ensure one of 24 final sampled residents (Resident 106) received a Level II mental health evaluation, after a Level 1 Screening was positive for serious mental illness, for one of three final sampled residents, reviewed for PASRR. This failure posed the risk for Resident 106 not receiving specialized services beneficial to the resident's wellbeing. Findings: Medical record review for Resident 106 was initiated on 1/21/25. Resident 106 was discharged from Acute Care Hospital 1 on 11/19/24, and then admitted to the facility on [DATE]. Review of Resident 106's Level 1 PASRR screening (completed at Acute Care Hospital 1) dated 11/18/24, showed Resident 106 was positive for serious mental illness and a Level II mental health evaluation referral was required. Review of Resident 106's Unable to Complete Level II Evaluation for Serious Mental Illness dated 11/18/24, showed a Level II Mental Health Evaluation was not scheduled for the following reason: Resident 106 was discharged from the facility (Acute Care Hospital 1). The case is now closed. To reopen, the facility must submit another screening. On 1/23/25 at 1037 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 was asked if the California Department of Health Care Services Level II evaluators were aware Resident 106 currently resided in the facility. RN 1 reviewed Resident 106's medical record and verified there was no documentation showing the California Department of Health Care Service Level II evaluators were aware of Resident 106's admission to the facility. RN 1 stated status post admission to the facility, the facility should have completed another PASRR Level 1 screening to ensure (if needed) Resident 106 received a Level II Mental Health Evaluation, to determine if Resident 106 could benefit from specialized services.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on interview, medical records, and facility P&P review, the facility failed to ensure two of three final sampled residents (Residents 28 and 53) reviewed for PASRR were accurately screened. * The facility failed to ensure Residents 28 and 53 PASRR screenings were completed by the appropriate facility staff member. In addition, the facility failed to verify with DHCS when Resident 53's PASRR Level 1 screening was closed due to the facility staff not responding to two or more separate attempts of communication by DHCS. These failures posed the risk for Residents 28 and 53 not properly screened, and the risk to not receive adequate level of services, comprehensive assessment, intervention and evaluation for conditions related to Residents 28 and 53's mental disorder. Findings: 1. According to https://www.dhcs.ca.gov/services/MH/Pages/PASRR_faq_level1.aspx: -It is the facility's responsibility to designate a qualified staff that can complete Level 1 screenings. The facility staff must have knowledge of medical terminology, knowledge related to the medical/ behavioral history and current status of the individual, and met the individual or individual's family/ conservator and be directly involved in the individual's care; and - Under the Resolutions on Level 1 Case list section, showed the different types of resolutions included L1 - Categorical Review, which meant the case is with DHCS for further review. If the individual cannot benefit from specialized mental health services, a Categorical Letter will be available after the review has been completed. Review of the facility's P&P titled PASRR (Preadmission Screening Resident Review) revised 3/2019 showed the following: -A tentative result of either negative or positive will appear on the Level 1 screening after it has been submitted online. A tentative resolution of Level 1 - Categorical Review may also appear. The facility should periodically review the status until it reaches the closed status; and -If the results of the Level 1 Screening indicate Categorical Review, the Level 1 Screening will be submitted to DHCS for further review. The Level 1 Case List should be reviewed periodically online until the case is resolved. Medical record review for Resident 53 was initiated on 1/26/25. Resident 53 was readmitted to the facility on [DATE]. Review of Resident 53's PASRR Level 1 Screening dated 8/6/24, showed the Business Office Manager completed the screening. Further review of the PASSR showed an L1 - Categorical Review resolution. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Notice of Attempted Evaluation letter from DHCS dated 8/6/24, showed unable to complete Level II evaluation for serious mental illness, and SMI Level II Mental Health Evaluation was not scheduled for the following reason: facility staff were unresponsive to two or more separate attempts of communication within 48 hours of the Level 1 Screening. The case is now closed. To reopen, the facility must resubmit a new Level I Screening. Further review of Resident 53's medical record failed to show a documented evidence a follow-up call or inquiry was sent to DHCS, nor a new Level 1 Screening was submitted. 2. Medical record review for Resident 28 was initiated on 1/26/25. Resident 28 was readmitted to the facility on [DATE]. Review of Resident 28's PASRR Level 1 Screening dated 12/5/23, showed the Business Office Manager completed the screening. On 1/24/25 at 1043 hours, an interview and concurrent medical record review for Residents 28 and 53 was conducted with RN 1. RN 1 verified the PASSR screenings forms for Resident 28 and 53 showed the Business Office Manager completed the form. RN 1 stated only the Business Office Manager's computer had the access to the PASSR website, so the nurses used the Business Office Manager's computer access to complete the PASSR screening. When asked regarding completion of Resident 53's Level 1 screening as stated in the DHCS letter, RN 1 verified Resident 53's Level 1 screening was for categorical review, and a letter was sent by the DHCS showing the screening was not completed because the facility staff was unresponsive after two or more attempts of communication 48 hours after the Level 1 screening. RN 1 could not find documented evidence the DHCS letter was followed up or a new PASSR Level 1 screening was submitted for Resident 53.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49258 Based on interview and medical record review, the facility failed to provide the necessary services as ordered by the physician for one of one sampled resident reviewed for physician's consult (final sampled resident, Resident 82). * The facility failed to ensure the dermatology consult was provided to Resident 82 as ordered. This failure had the potential for the resident not to receive the necessary care and services. Findings: During the initial tour of the facility on 1/21/25 at 0905 hours, Resident 82 was observed awake and lying in bed. Resident 82's left forearm was observed with an intact foam dressing. Resident 82 stated he had a wound in his left forearm, and he was getting treatment for it. Medical record review for Resident 82 was initiated on 1/23/25. Resident 82 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 82's H&P examination dated 7/3/24, showed Resident 82 had no capacity to understand and make decisions. Review of Resident 82's Order Summary Report showed the following: - a physician's order dated 11/25/24, for dermatology consult with Physician 1 on 12/9/24 at 1530 hours; and - a physician's order dated 12/15/24, to cleanse left forearm open lesion with normal saline solution, pat dry, and cover with foam dressing every day for 30 days and was reordered on 1/14/25. Review of Resident 82's Care Plan initiated 11/15/24, showed a care plan problem addressing Resident 82's left forearm open lesion. The approach plans included a dermatology consult per the physician's order. Review of Resident 82's Non-Pressure Skin Condition Report dated 1/20/25, showed the left forearm lesion's size was decreased from 1.5 cm (length) x 1.5 cm (width) to 1.4 cm (length) x 1.4 cm (width), wound bed was pink, no drainage, and no odor. Further review of Resident 82's medical record failed to show documented evidence Resident 82's was seen by Physician 1 for a dermatology consult. On 1/23/25 at 1030 hours, a concurrent interview and medical record review was conducted with LVN 5. LVN 5 stated the facility requested a wrong transportation for Resident 82 on 12/9/24. LVN 5 stated a regular car was requested for Resident 82 instead of a van transportation. LVN 5 stated Resident 82 was wheelchair bound. LVN 5 further stated Resident 82 ended up not leaving the facility on 12/9/24. LVN 5 verified the dermatology consult for Resident 82 was not rescheduled. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/23/25 at 1108 hours, a telephone conversation was conducted with the Doctor's Clinic Medical Assistant. The Doctor's Clinic Medical Assistant verified Resident 82 had an appointment scheduled with Physician 1 on 12/9/24 at 1530 hours, but Resident 82 did not show up. The Doctor's Clinic Medical Assistant further stated Resident 82 did not have any new appointment scheduled with Physician 1 after that. On 1/23/25 at 1445 hours, a concurrent interview and medical record review was conducted with RN 3. RN 3 stated the licensed nurses should schedule the physician's appointment when an order was received and if the resident had no family member who could bring the resident to a physician's appointment, the facility will coordinate with the transportation. RN 3 stated if the resident missed the scheduled physician's appointment, the licensed nurses should make a new appointment for the resident and any follow up regarding this should be documented. RN 3 further stated the resident could not miss any physician's appointment. RN 3 verified there was no follow up done regarding Resident 82's dermatology consult. On 1/27/24 at 1445 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Resident 82.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, medical record review, interview, and facility P&P review, the facility failed to provide the necessary restorative nursing services for one of three final sampled resident (Resident 53) reviewed for positioning and mobility. * The facility failed to ensure Resident 53 was applied carrot splint to both hands, and AFO to both feet for four hours as tolerated, per the physician's order. This failure had the potential for Resident 53's hand and foot contractures to worsen. Findings: Review of the facility's P&P titled Splint Application revised date 5/2017 showed the following: -It is the policy of the facility that splints be applied correctly to maintain the resident's range of motion and prevent contractures and further loss of range of motion; -Once the orthosis is received, the RNA is responsible of the application and removal of the splint; and -The splint is usually left in place for six days a week for a period of two hours per day, as tolerated. On 1/21/25 at 0948 hours, during the initial tour of the facility, Resident 53 was observed in bed, and both hands were observed contracted. There were no splints observed to both hands. Resident 53 was observed with splints to both feet. Medical record review for Resident 53 was initiated on 1/21/25. Resident 53 was readmitted to the facility on [DATE]. Review of Resident 53's MDS dated [DATE], showed Resident 53 had severe cognitive impairment, dependent to facility staff member assistance for self-care and mobility, and had impairment on upper and lower extremities. Review of Resident 53's Order Summary Report showed the following physician's orders dated 6/11/24: - RNA to apply left AFO splint for five days per week for four hours as tolerated; - RNA to apply left hand carrot splint for five days per week for hours as tolerated; - RNA to apply right AFO splint for five days per week for hours as tolerated; and - RNA to apply right hand carrot splint for four hours as tolerated. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/25 at 1214 and 1545 hours, Resident 53 was observed in bed, and with rolled towels were observed on both hands. On 1/23/25 at 0833 hours, Resident 53 was observed in bed, and with the carrot splints on both hands. On 1/23/25 at 1021 hours, an interview and concurrent medical record review for Resident 53 was conducted with RNA 1. RNA 1 stated the restorative nursing department was responsible for applying and removing the splints. RNA 1 stated they document the application of the splint in the Restorative Nursing form. Review of Resident 53's Restorative Nursing form for January 2025 showed Resident 53 was applied with the carrot splint on both hands, and AFO on both feet for two minutes daily for five days per week. RNA 1 verified the above findings. RNA 1 stated they only documented the number of minutes spent in the application of the splint, and not the number of hours Resident 53 had the splints on. RNA 1 failed to show documented evidence of how many hours Resident 53 had the carrot splints on both hands, and the AFO on both feet. On 1/27/25 at 0955 hours, an interview and concurrent medical record review for Resident 53 was conducted with the DON. The DON verified the above findings. The DON stated the RNAs should be documenting the number of hours Resident 53 had the carrot splint on both hands, and the AFO on both feet to know if the resident tolerated the splints.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of three final sampled residents (Resident 28) reviewed for elopement was free from accident hazards. * The facility failed to document Resident 28's wandering and/or exit-seeking behaviors and failed to conduct her elopement assessment accurately. Resident 28 was not assessed to be a high risk for elopement; however, the facility staff had observations of the resident verbalizing she wanted to go home or she wanted to leave the facility with her daughter, wandering around the facility, episodes of going outside the facility, and standing by the locked front door to wait for her daughter so she could leave the facility. In addition, the facility failed to provide Resident 28 with an ID bracelet as per the elopement assessment plan. This failure had the potential to not follow the elopement protocol for Resident 28, and the risk for Resident 28 to not be identified immediately and could result to a delay to locate what facility Resident 28 belonged to in an elopement incident. Findings: Review of the facility's P&P titled Wandering/ Exit-Seeking Behavior revised 9/2019 showed the following: - The facility will evaluate residents for wandering and/or exit-seeking behavior and implement appropriate interventions as indicated via the evaluation process; and - If the resident exhibits wandering and/or exit-seeking behavior, the episodes should be documented in the progress notes of the medical record. Documentation should include interventions used and their effectiveness. On 1/21/25 at 0934 hours, during the initial tour of the facility, Resident 28 was observed in bed. Resident 28 was not observed with an ID bracelet. On 1/21/25 at 0936 hours, an interview was conducted with CNA 3. CNA 3 stated she was assigned to care for Resident 28. CNA 3 stated Resident 28 could get up by herself, and she wandered in the facility, and goes outside the facility. Medical record review for Resident 28 was initiated on 1/21/25. Resident 28 was admitted to the facility on [DATE]. Review of Resident 28's H&P examination dated 11/7/24, showed the resident had no capacity to understand and make decision. Review of Resident 28's Elopement Risk assessment dated [DATE], showed a score of 17 or higher is considered high risk for elopement. Resident 28 was assessed with no history of elopement and has accepted placement or a new admit, and had a score of 16. The assessment showed the plan for the resident was to have an ID bracelet, and the staff members were aware of the resident's risk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 28's plan of care failed to show a care plan problem to address the resident's risk for elopement. Review of Resident 28's medical record did not show documentation of Resident 28's wandering around the facility and episodes of going outside the facility. On 1/24/25 at 0847 hours, Resident 28 was observed in bed. Resident 28 was not observed with an ID bracelet. On 1/24/25 at 0902 hours, an interview for Resident 28 was conducted with CNA 6. CNA 6 stated Resident 28 wanted to get out of the facility, and the resident would often say she was leaving, and wanted to go outside with her daughter. CNA 6 stated Resident 28 had tried to leave the facility about a month ago, but she never got out, because the resident had always someone to get her back to her room. CNA 6 stated Resident 28 had a bracelet, and a Wander Guard. On 1/24/25 at 0915 hours, observation for Resident 28 and concurrent interview was conducted with CNA 6. Resident 28 was observed in bed. Resident 28 was not observed with an ID bracelet nor a Wander Guard. On 1/24/25 at 1033 hours, a follow-up interview was conducted with CNA 6. CNA 6 stated she spoke to the DSD about Resident 28, and per the DSD, Resident 28 did not have an ID bracelet because the resident refused, and it has been care planned. On 1/24/25 at 1034 hours, an interview and concurrent medical record review for Resident 28 was conducted with RN 1. RN 1 stated Resident 28 had wandered around the facility, and stood by the front door at times. RN 1 verified there was no documentation Resident 28's wandering around the facility, behavior of verbalizing her desire to go home or to leave the facility with her daughter, nor her behavior of going to the locked front door to wait for her daughter so she could leave the facility. RN 1 also verified there was no documentation Resident 28 was provided with an ID bracelet nor a documentation to show Resident 28 had refused or had taken off her ID bracelet. RN 1 also verified there was no care plan developed when Resident 28 was non-compliant with her ID bracelet. On 1/24/25 at 1307 hours, an interview and concurrent medical record review for Resident 28 was conducted with the DSD. The DSD stated Resident 28 had history of saying she wanted to go home, or Resident 28 thought she was getting picked up. The DSD stated Resident 28 was observed packing her things while saying she was going home and would go to the locked front door. The DSD stated Resident 28 had never physically attempted to open the door or sneaked out of the facility but would stand by the door and would look for the person to pick her up. The DSD stated Resident 28 took off her ID bracelet and was non-compliant with the ID bracelet. The DSD verified there was no documentation Resident 28 was provided with an ID bracelet nor refused or had taken off her ID bracelet. The DSD also verified there was no care plan developed when Resident 28 was non-compliant with having an ID bracelet.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51920 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services related to the GT feeding were provided for one of three final sampled residents (Resident 62) reviewed for tube feeding. * The facility failed to ensure Resident 62's GT feeding rate was updated according to the physician's orders and failed to ensure Resident 62's GT feeding care plans were revised. These failures posed the risk for not providing the necessary GT care and interventions to Resident 62. Findings: Review of the facility's P&P titled Gastrostomy Tube Feeding via Continuous Pump revised 1/2017 showed it is the policy of the facility to provide nourishment via continuous pump to the residents who are unable to obtain adequate nourishment orally, as ordered by the resident's attending physician. On 1/22/25 at 1413 hours, Resident 62's GT feeding formula was observed running at 60ml/hr via GT feeding pump. Medical record review for Resident 62 was initiated on 1/22/25. Resident 62 was readmitted to the facility on [DATE]. a. Review of Resident 62's Nutritional assessment dated [DATE], showed the RD recommendation to increase the Jevity 1.5 (a GT feeding formula) to 65 ml/hr for 20 hrs to provide 1300 cc/1950 kcal. Review of Resident 62's Order Summary Report showed the following physician's orders: - on 8/27/24, for Jevity 1.5 at 60 ml/hr (1200 ml/1800 kcal) via enteral feeding pump for 20 hours, to start at 1400 hours and off at 1000 hours or until dose is completed. - on 9/14/24, to infuse water at 35 ml/hr (700 ml/day) via enteral feeding pump for 20 hours, to start at 1400 hours and off at 1000 hours or until dose is completed. The Order Summary dated 9/14/24, further showed to increase the GT feeding to Jevity 1.5 at 65 ml/hour for 20 hours. b. Review of Resident 62's Plan of Care initiated on 4/7/24, showed a care plan problem addressing the use of the feeding tubes. The interventions included to provide the entering feeding formula, Jevity 1.5 at 60 ml/hr for 20 hours as per the RD recommendation on 8/27/24. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/25 at 1426 hours, a concurrent observation, interview, and medical record review was conducted with LVN 6. LVN 6 verified there were two conflicting GT enteral feeding orders for Resident 62. LVN 6 verified Resident 6's GT feeding pump was set and running at 60 ml/hr and acknowledged it was an incorrect rate. LVN 6 also verified Resident 6's GT feeding care plans were not revised to reflect the new order on 9/14/24.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services for one of one final sampled resident (Resident 37) reviewed for dialysis care. * The facility failed to ensure Resident 37's vital signs and weight were monitored post-dialysis. This failure had the potential for delay in the provision of care to Resident 37 for complications of the dialysis treatment. Findings: Review of the facility's P&P titled Dialysis Care revised 2/2018 showed the following: - The Pre-Dialysis Checklist will be completed by the facility each time the resident is scheduled for dialysis. This checklist includes the vital signs; - The Dialysis Unit Progress will accompany the resident to dialysis and requests that the dialysis unit complete with the pre- and post-dialysis weight and vital signs; and - The Post-Dialysis Checklist is to be completed by the facility upon the return of the resident. Information to be documented included the vital signs. Review of the facility's P&P titled Dialysis - Post Dialysis Care revised 4/2017 showed upon return from the dialysis facility, the resident's vital signs should be taken. Medical record review for Resident 37 was initiated on 1/21/25. Resident 37 was admitted to the facility on [DATE]. Review of Resident 37's Order Summary Report showed a physician's order dated 10/4/24, showed Resident 37 was scheduled to have dialysis on Tuesdays, Thursdays, and Saturdays. * Review of Resident 37's Pre and Post Dialysis Checklist did not show Resident 37's vital signs were monitored upon the resident's return from the dialysis facility on 12/21, 1/2, 1/4, 1/9, 1/14, 1/16, and 1/18/25. * Review of Resident 37's Dialysis Unit Progress form dated 1/18/25, did not show a post-dialysis weight for Resident 53 while in the dialysis unit. * Review of Resident 37's Weights and Vitals Exceptions did not show Resident 37's vital signs were monitored upon her return from dialysis on 12/21, 1/2, 1/4, 1/9, 1/14, 1/16, and 1/18/25. Review of Resident 37's Nurses Progress Notes did not show Resident 37's vital signs were monitored upon her return from the dialysis facility on 12/21, 1/2, 1/4, 1/9, 1/14, 1/16, and 1/18/25, and her post-dialysis weight on 1/18/25, was followed-up with the dialysis unit. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/24/25 at 1000 hours, an interview and concurrent medical record review for Resident 37 was conducted with RN 1. RN 1 verified the above findings. RN 1 verified there was no documentation to show Resident 37's vital signs were monitored upon her return from the dialysis facility on 12/21/24, and on 1/2, 1/4, 1/9, 1/14, 1/16, and 1/18/25, and her post-dialysis weight on 1/18/25. RN 1 also verified Resident 37's post-dialysis weight on 1/18/25, was not followed-up with the dialysis facility.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49258 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of four sampled residents (nonsampled resident, Resident 13) reviewed for side rail use remained free from accident hazards due to the use of side rails. * The facility failed to obtain the physician's order and informed consent, review the risks and benefits, provide the least restrictive alternatives, and develop the plan of care for Resident 13's use of the side rails. This failure had the potential to place the resident at risk for entrapment and serious injury. Findings: Review of the facility's P&P titled Side Rails or Bed Rails revised 8/2018 showed the following: - Informed consent for the physical restraint, including the use of bed or side rails even for episodic use is required to be obtained from the resident or legal representative. Potential negative outcomes and benefits should be discussed. The use of anything attached to a normal bed (i.e. one-fourth rails as an enabler, grab bar attached to the bed, any assistive device, etc.) requires a comprehensive care assessment, physician's order, informed consent, and a care plan to address the use. - The facility will attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used even for episodic use, the facility will make sure that it is installed correctly, used correctly and maintained. The resident will be assessed for the risk of entrapment from bed rails prior to its installation. During the initial tour of the facility on 1/21/25 at 0958 hours, Resident 13 was observed awake and sitting in the wheelchair beside the bed. The bed was observed with the bilateral upper side rails elevated. Resident 13 stated he uses the side rails during turning or when he was getting out of the bed. On 1/22/25 at 0934 hours, a concurrent observation and interview was conducted with Resident 13. Resident 13 was observed awake and lying in the bed with the bilateral upper side rails elevated. Resident 13 stated he had been using the side rails for a long time and not just a month ago. Resident 13 further stated he needed the side rails to grab when turning from side to side or when he was getting out of the bed. Medical record review for Resident 13 was initiated on 1/22/25. Resident 13 was readmitted to the facility on [DATE]. Review of Resident 13's H&P examination dated 4/30/24, showed Resident 13 had the capacity to understand and make decisions. The H&P examination also showed Resident 13 had a significant diagnosis of morbid obesity. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 13's MDS dated [DATE], showed Resident 13 required partial to moderate assistance from staff member for bed mobility. Further review of Resident 13's medical record failed to show documented evidence a physician's order for the use of the side rails, an informed consent were obtained, the least restrictive alternatives were attempted prior to the use of side rails, and the plan of care for the use of side rails was developed. On 1/22/25 at 1553 hours, a concurrent observation and interview was conducted with CNA 5. CNA 5 was observed getting out from Resident 13's room. CNA 5 stated when Resident 13 was in bed, the bilateral side rails were elevated at all times. CNA 5 further stated Resident 13 grabbed on the side rails when being assisted with turning. On 1/23/25 at 1418 hours, a concurrent interview and medical record review for Resident 13 was conducted with LVN 1. LVN 1 stated prior to the use of the side rails, the resident should be assessed initially for the need of side rails, and the least restrictive alternatives should be attempted first like two person assistance, or the use of pillows or overhead trapeze. LVN 1 stated a physician's order and informed consent should be obtained and the care plan should also be developed to address the use of the side rails. LVN 1 verified there were no physician's order, informed consent, the least restrictive alternatives were not attempted, and the plan of care was not developed for Resident 13's use of the bilateral side rails. On 1/27/24 at 1445 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Resident 13. Cross reference to F909, example #1.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50967 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary pharmaceutical services to one final sampled resident (Resident 82) and one nonsampled resident (Resident 20). * The facility failed to ensure Resident 20's medications were administered as ordered by the physician and accurately documented in the MAR. * The facility failed to ensure the documentation for Resident 82's controlled medication administrations were accurate and complete. * The facility failed to ensure the narcotic sheets inventory were properly conducted showing the nurses' initials and signatures for Medication Cart B. Theses failures had the potential for the resident not to receive the necessary medications and posed the risk for diversion of the medications. Findings: Reviewed of the facility P&P titled Medication Administration revised on 5/2019 showed the following: -Medications must be administered in accordance with the physician orders; -The licensed nurse administering the medication must initial the MAR for the resident on the appropriate line after giving the medication; and -The licensed nurse administering the medication will record on the MAR. 1. Medical record review for Resident 20 was initiated on 1/22/25. Resident 20 was admitted to the facility on [DATE]. Review of Resident 20's H&P examination dated 10/16/24, showed Resident 20 had the capacity to understand and make decisions. Review of Resident 20's MDS dated [DATE], showed Resident 20's Brief Interview for Mental Status (BIMS) score was 99 (indicates that the interview was incomplete. This can happen if the patient refused to participate, or if the patient's responses were nonsensical or not provided). On 1/21/25 at 0817 hours, a medication administration observation was conducted with LVN 1. LVN 1 prepared and administered the following medications for Resident 20: - allopurinol (a medication to prevent uric acid production in the body) 300 mg one tablet; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- folic acid (vitamin) 1 mg one tablet; - furosemide (diuretic used to treat fluid retention) 40 mg one tablet - Keppra (medication to prevent seizure) 100 mg/ml solution, 5 ml; - Ingrezza (used to treat symptoms of tardive dyskinesia) 40 mg one capsule; - memantine (medication use to treat memory loss) 10 mg one tablet; - potassium chloride (supplement) solution 15 ml; - Zoloft (medication for depression) 25 mg one tablet; - aspirin (medication used to prevent blood clot) chewable 81 mg one tablet; - ferrous sulfate (mineral the body need to produce red blood cells) 7.5 ml solution; - multivitamins (supplement) one tablet; - vitamin B-1 (supplement) 100 mg one tablet; and - vitamin D (supplement) 25 mcg 1000 IU one tablet. a. During the medication preparation for Resident 20, LVN 1 stated would not administer the docusate sodium (stool softener) 250 mg capsule until she clarified the order with the physician. Review of Resident 20's Order Summary Report showed a physician's order dated 12/31/24, to administer docusate sodium capsule 250 mg, give one capsule via GT one time a day for bowel management. Hold with loose stools or diarrhea. Review of Resident 20's MAR for January 2025 did not show the administration of docusate sodium per physician's order on 1/21/25. On 1/22/25 at 1023 hours, a follow-up interview was conducted with LVN 1. LVN 1 was asked if she administered the docusate sodium on 1/21/25 after she clarified the medication from the physician and LVN 1 stated, No, I did not give a dose of docusate sodium yesterday. b. On 1/21/25 at 0847 hours, an interview was conducted with LVN 1. LVN 1 stated she completed the medication administration for Resident 20's morning medications. Asked LVN 1 if she must document after medication administration, LVN 1 stated she had documented on Resident 20's MAR while preparing the medications. Furthermore, LVN 1 stated her usual process was to document on the MAR prior to the administration of medications. Review of Resident 20's Medication Administration Audit Report dated 1/21/25, showed the administration time for the morning medications were documented prior to the administration completion time. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/23/25 at 1457 hours, an interview was conducted with the DON. The DON stated medication administration process expectation must be to pour, pass, and sign the MAR. Furthermore, the DON stated the licensed nurses should administer the resident's medications as ordered by the physician. On 1/27/25 1400 at hours, an interview was conducted with the DON and Administrator. The DON and Administrator were informed and acknowledged the above findings. 45064 2. Medical record review for Resident 82 was initiated on 1/23/25. Resident 82 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident's 82's H&P examination dated 7/3/24, showed Resident 82 had no capacity to understand and make decisions. Review of Resident 82's Order Summary Report showed a physician's order dated 6/27/24, for tramadol HCL (medication relieve pain) oral tablet, give 50 mg by mouth every six hours as needed for moderate pain (pain level 1-5, using the 0-10 pain scale; zero meaning no pain and 10 meaning worst pain). Review of Resident 82's Antibiotic or Controlled Drug Record showed one tablet of the tramadol HCL 50 mg tablet was dispensed and signed out on 12/15/24 at 0900 hours. Review of Resident 82's MAR for December 2024 showed the documentation of the administration for the tramadol HCL 50 mg dispensed and signed out on 12/15/24 at 0900 hours was missing. On 1/23/25 at 1400 hours, an interview and concurrent record review was conducted with LVN 1. LVN 1 verified the above findings and stated she pulled and signed the tramadol tablet and administered the medication to Resident 82, but forgot to document in the MAR. 3. Review of the facility's P&P titled Controlled Medication Storage dated 8/2014 showed at each of the shift change, a physical inventory of all the controlled medications is conducted by two licensed nurses and is documented on the controlled medication accountability record. Review of Medication Cart B's Controlled Substances Book showed the Narcotic Check Sheet had multiple missing nurses' signatures during the shift change on the following dates and times: - on 6/20, 6/23, 7/21, 7/26, 8/7, 8/16, 8/30, 9/22, 10/19, and 12/22/24 at 0700 hours; - on 6/7, 6/9, 6/22, 6/23, 7/17, 8/5, 8/7, 8/12, 8/19, 8/30, and 10/19/24; and 1/7/25 at 1500 hours; and - on 6/9, 6/15, 6/24, 7/14, 7/17 , 7/25, 8/5, 8/7, 8/12, 8/19, 9/21, 9/22/24; and 1/5 and 1/18/25 at 2300 hours. On 1/23/25 at 1418 hours, a concurrent interview and facility document review was conducted with RN 1. RN 1 reviewed Medication Cart B Narcotic Sheet Check and verified there were missing nurses' signatures during the narcotic inventory at the beginning of each shift for the above dates and times.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on interview and medical record review, the facility failed to ensure two of 24 final sampled residents (Residents 37 and 53) were free from unnecessary drugs. * The facility failed ensure Resident 37 was not administered metoprolol (medication to treat high blood pressure) and clonidine (medication to treat high blood pressure) medications when Resident 37's blood pressure was below the parameter prescribed by the physician. * The facility failed to ensure Resident 53 was administered with metoprolol medication when Resident 53's blood pressure was below the parameter prescribed by the physician. These failures had the potential for the residents to develop the significant side effects such as hypotension and negatively affect the residents' health condition and well-being. Findings: 1. According to DailyMed, the most common adverse effects of the metoprolol and clonidine medications included hypotension. Medical record review for Resident 37 was initiated on 1/21/25. Resident 37 was readmitted to the facility on [DATE]. Review of Resident 37's Order Summary Report showed the following physician's orders dated 10/2/24: - To administer clonidine 0.2 mg one tablet by mouth in the morning for hypertension and hold if SBP is less than 110 mmHg; and -To administer metoprolol 100 mg one tablet by mouth for hypertension and hold if SBP is less than 110 mmHg or heart rate less than 60 beats per minute. Review of Resident 37's MARs for December 2024 and January 2025 showed Resident 37 was administered the metoprolol medication on the following: - dated 12/19/24 at 0900 hours, with a blood pressure of 109/57 mmHg; - dated 1/3/25 at 2100 hours, with a blood pressure of 104/56 mmHg, and - dated 1/14/25 at 0900 hours, with a blood pressure of 101/57 mmHg. In addition, the MAR showed Resident 37 was administered the clonidine medication on 12/26/24 at 0900 hours, with a blood pressure of 99/55 mmHg. The MARs for December 2024 and January 2025 showed the use of the metoprolol and clonidine medications ordered parameters were not followed. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/24/25 at 1000 hours, an interview and concurrent medical record review for Resident 37 was conducted with RN 1. RN 1 verified the above findings. RN 1 verified the metoprolol and clonidine medications were administered to Resident 37 when the resident's blood pressures were below the parameter prescribed by the physician. 2. Medical record review for Resident 53 was initiated on 1/21/25. Resident 53 was readmitted to the facility on [DATE]. Review of Resident 53's Order Summary Report showed the following physician's order dated 5/12/24, to administer metoprolol 25 mg one tablet by mouth for hypertension and hold if SBP is less than 120 mmHg or heart rate less than 50 beats per minute. Review of Resident 53's MARs for December 2024 and January 2025 showed Resident 53 was administered the metoprolol medication on the following: - dated 12/1/24 at 0900 hours, with a blood pressure of 116/77 mmHg, - dated 12/13/24 at 0900 hours, with a blood pressure of 116/77 mmHg, - dated 12/26/24 at 1700 hours, with a blood pressure of 115/79 mmHg, and - dated 1/3/25 at 0900 hours, with a blood pressure of 114/78 mmHg. On 1/23/25 at 1325 hours, an interview and concurrent medical record review for Resident 53 was conducted with RN 3. RN 3 verified the above findings. RN 3 verified the metoprolol medication was administered to Resident 53 when the resident's blood pressures were below the parameter prescribed by the physician.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure 7 of 11 final sampled residents (Residents 12, 13, 28, 37, 44, 53, and 73) reviewed for unnecessary medications were free from unnecessary psychotropic drugs. * The facility failed to ensure Resident 37's was accurately monitored related to the use of Remeron (antidepressant medication). Resident 37's meal intake documentation was inconsistent, showing either a % or a hashmark, and did not match the CNA's Documentation Survey Report. In addition, the monthly behavior summary of the episodes of Resident 37's meal intake less than 50% did not match the MAR nor the CNA's Documentation Survey Report. * The facility failed to renew the informed consent related to the use of Depakene (mood stabilizer medication), Remeron (antidepressant medication), and risperidone (antipsychotic medication) for Resident 53. In addition, the facility failed to monitor Resident 53's blood pressure for orthostatic hypotension was monitored as ordered by the physician related to the use of risperidone. * The facility failed to ensure Resident 73 was monitored for the side effects related to the use of lorazepam (antianxiety medication). * The facility failed to ensure the informed consent was obtained prior to the administration of risperidone for Resident 28. * The facility failed to ensure Resident 13's the informed consents for trazodone, Zyprexa, and bupropion were renewed after 6 months. * The facility failed to ensure Resident 12's informed consents for Seroquel and Depakote were renewed after 6 months. * The facility failed to ensure Resident 44's informed consents for Depakote ER, fluvoxamine maleate, olanzapine, and risperidone were renewed after six months. These failures had the potential for the residents to have adverse complications from the medications and the potential of not providing the correct data to the prescriber in order to adjust the dose of the psychotropic medications for the residents. In addition, these failures had the potential for the residents and their responsible parties not being informed of their medications and the potential side effects of the psychotropic medications. Findings: Review of the facility's P&P titled Informed Consent Policy revised 4/2024 showed the following: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- There is a requirement for the facility to renew informed consent every six months. There is no need to renew the consent form if the dosage or therapy is being decreased unless it has been six months. There is no need to renew informed consent if the resident is transferred to a hospital and returns with no change in orders and the facility has a copy of the informed consent in the resident's clinical record unless it has been more than six months since consent has been renewed; and - The facility shall verify that informed consent has been informed prior to the administration of psychotherapeutic medication. Review of the facility's P&P titled Psychotropic Drug Treatment dated 9/2017 showed the following: - The resident or his/ her representative will be given information regarding the need for, the desired effect and the potential side effects of the medication. This enables the resident or his/ her representative to make an informed consent regarding the use of any psychoactive medication. The resident or their representative should be involved in the medication management process and aware of the benefits and risks of medications and the goals of treatment; and - Each resident's drug regimen review must be free from unnecessary drugs. Unnecessary drugs are any drugs when used without adequate monitoring. Review of the facility's P&P titled Informed Consent revised 4/2024 showed it is the policy of the facility that if the attending physician, physician assistant (PA), or nurse practitioner (NP) for a resident prescribes, orders, or increase an order for a psychotherapeutic medication the physician, PA or NP or the facility shall do the following: - There is a requirement for the facility to renew informed consent every six months. There is no need to renew the consent form if the dosage or therapy is being decreased unless it has been six months. 1. Medical record review for Resident 37 was initiated on 1/21/25. Resident 37 was readmitted to the facility on [DATE]. Review of Resident 37's H&P Examination dated 10/4/24, showed Resident 37 had the capacity to understand and make decision. Review of Resident 37's Order Summary Order showed the following physician's orders dated 10/2/25: - To administer Remeron 22.5 mg by mouth at bedtime for depression manifested by poor oral intake less than 50% meal; and to - To monitor meal percentage less than 50% related to the use of Remeron. Review of Resident 37's MAR for December 2024 and January 2025 showed the following: - Resident 37 was administered Remeron 22.5 mg on 12/1 to 12/31/24, and from 1/1 to 1/22/25; and (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident 37's meal intake was 10 on 12/30/24 at 1700 hours, and on 12/31/24 at 1200 and 1700 hours; 20 on 12/23/24 at 1200 hours, and 12/31/24 at 0700 hours; 50 on 12/26 and 12/27/24 at 0700 and 1200 hours, and on 12/26/24 at 1700 hours; and 60 on 12/28/24 at 0700 and 1200 hours, and 12/27/24 at 1700 hours. However, Resident 37's meal intake was 1 on 12/7/24 at 0700 hours, 12/14 and 12/19/24 at 1700 hours, 12/24/24 at 1200 hours, on 12/10, 12/11, 12/10, 12/11, 12/22, and 12/29/24 at 0700 and 1200 hours, and on 12/8, 12/15, 12/20, and 12/21/24 at 0700, 1200, ad 1700 hours. In addition, Resident 37 meal intake was 0 on 12/7/24 at 1200 hours, 12/10 12/11, 12/22, 12/23, 12/28 and 12/29/24 at 1700 hours, on 12/14, 12/19 and 12/30/24 at 0700 and 1200 hours, and on 12/1 to 12/6/25, 12/12, 12/13, 12/16, and 12/25/24 at 0700, 1200 and 1700 hours; and - Resident 37's meal intake was 20 on 1/1/25 at 0700, hours; 30 on 1/2/25 at 0700 and 1200 hours; 50 on 1/5/25 at 1700 hours; and 40 on 1/7/25 at 0700 hours. However, Resident 37's meal intake was X on 1/14/25 at 1700 hours, and 0 on 1/7 and 1/13 at 0700 hours, and on 1/3 and 1/4/25 at 1700 hours. In addition, Resident 37's meal intake was 1 on 1/2/25 at 1200 and 1700 hours, on 1/3, 1/4, 1/5 and 1/14/25 at 0700 and 1200 hours, on 1/6/25 at 1200 and 1700 hours, and on 1/8 to 1/12/25 at 0700, 1200, and 1700 hours, and in 1/14 to 1/22/25 at 0700, 1200, and 1700 hours. Review of Resident 37's CNA - Documentation Survey Report for December 2024 and January 2025 showed Resident 37 consumed less than 50% for 75 out of 93 meals for December 2024, and 59 out of 71 meals for January 2025. a. Further review of Resident 37's meal intake documentation in the MAR was inconsistent, showing either a % or a hashmark Resident 37's monitoring of meal intake at 0700, 1200 and 1700 hours, was documented either as NA, X, 0, 1, 10, 20, 30, 40, 50, or 60. In addition, Resident 37's meal intake documentation in the MAR did not match Resident 37's meal intake documentation in the CNA - Documentation Survey Report. Review of Resident 37's Behavior and Psychotropic Summary/Dosage Reduction for December 2024 for Resident 37's poor meal intake less than 50 % related to use of Remeron showed Resident 37 had 14 episodes at 0700 hours, 12 episodes at 1200 hours, and 10 episodes at 1700 hours, for a total of 36 episodes for December 2024. b. Further review of the monthly behavior summary of the episodes of Resident 37's meal intake less than 50% did not match the MAR nor the CNA - Documentation Survey Report. On 1/24/25 at 1000 hours, an interview and concurrent medical record review for Resident 37 was conducted with RN 1. RN 1 verified the above findings. RN 1 stated the licensed nurses should verify with the CNAs regarding Resident 37's meal intake, and the licensed nurses should be documenting the percentage of Resident 37's meal intake in the MAR. 2. Medical record review for Resident 53 was initiated on 1/21/25. Resident 53 was readmitted to the facility on [DATE]. Review of Resident 53's H&P examination dated 5/14/24, showed Resident 53 had no capacity to understand and make decision. Review of Resident 53's Order Summary Order showed the following physician's orders: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 5/12/24, to administer Depakene 250 mg/ml 10 ml via GT two times a day for mood stabilizer/ labile mood. This physician's order was discontinued on 1/10/25. - dated 5/27/24, to monitor blood pressure lying and sitting for orthostatic hypotension every week on Tuesday in 1500 to 2300 hours shift related to the use of risperidone. Notify the physician if the difference in SBP of 20 mmHg or if the difference in DBP of 10 mmHg or greater. - dated 12/12/24, to administer Remeron 7.5 mg via GT at bedtime for depression; - dated 12/12/24, to administer risperidone 0.5 mg via GT at bedtime; and a. Review of Resident 53's Informed Consent dated 5/16/24, showed an informed consent was obtained for the Risperdal (risperidone), Depakene, and Remeron medications. However, the informed consent for Risperdal, Depakene, and Remeron medications was not renewed after six months. b. Review of Resident 53's MAR for December 2024 and January 2025 showed the following: - Resident 53 was administered Depakene 250 mg/5 ml 10 ml via GT on 12/1 to 12/31/24 at 0900 and 1700 hours, on 1/1 to 1/9/25 at 0900 and 1700 hours, and on 1/10/25 at 0900 hours; - Resident 53 was administered Remeron 7.5 mg via GT on 12/12 to 12/31/24 at 2100 hours, and on 1/1 to 1/22/25 at 2100 hours; - Resident 53 was administered risperidone 0.5 mg via GT on 12/12 to 12/31/24 at 2100 hours, and on 1/1 to 1/22/25 at 2100 hours; and - Resident 53's blood pressures were monitored for orthostatic hypotension related to the use of risperidone. However, the blood pressure readings for both positions (lying and sitting) were the same as follows: - On 12/3/24, the blood pressure readings were 128/78 mmHg for the lying position and 128/78 mmHg for the sitting position; - On 12/17/24, the blood pressure readings were 140/75 mmHg for the lying position and 140/75 mmHg for the sitting position; - On 12/31/24, the blood pressure readings were 131/77 mmHg for the lying position and 131/77 mmHg for the sitting position; - On 1/14/25, the blood pressure readings were 133/75 mmHg for the lying position and 133/75 mmHg for the sitting position; and - On 1/22/25, the blood pressure readings were 142/83 mmHg for the lying position and 142/83 mmHg for the sitting position. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/23/25 at 1043 hours, an interview and concurrent medical record review for Resident 53 was conducted with RN 1. RN 1 verified the above findings. RN 1 acknowledged the informed consent for the Risperdal, Depakene, and Remeron medications was not renewed after six months. RN 1 also verified the licensed nurses were not checking for orthostatic hypotension accurately because of the same blood pressure readings for both sitting and lying positions. 3. Medical record review for Resident 73 was initiated on 1/21/25. Resident 73 was readmitted to the facility on [DATE]. Review of Resident 73's H&P Examination dated 7/20/24 showed Resident 73 could make needs known but cannot make medical decisions. Review of Resident 73's Order Summary Order showed the following physician's orders: - dated 1/14/25, to monitor behavior of striking out towards the staff during care every shift. - dated 1/17/25, to administer lorazepam 0.5 mg one tablet two times a day for anxiety manifested by striking out, for 14 days; Review of Resident 73's MAR for January 2025 showed Resident 73 was administered the lorazepam medication from 1/19 to 1/20/25 at 1700 hours, and on 1/22 to 1/25/25 at 0900 and 1700 hours. Further review of Resident 73's medical record did not show Resident 73 was monitored for the side effects related to the use of the lorazepam medication. On 1/27/25 at 0948 hours, an interview and concurrent medical record review for Resident 53 was conducted with the DON. The DON verified the above findings. The DON stated the licensed nurses had to make sure the resident was monitored for the behavior and side effects related to the use of psychotropic medications. 4. Medical record review for Resident 28 was initiated on 1/21/25. Resident 28 was readmitted to the facility on [DATE]. Review of Resident 28's H&P Examination dated 11/7/24, showed Resident 28 had no capacity to understand and make decision. Review of Resident 28's Order Summary Order showed the following physician's orders dated 1/21/25: - To administer risperidone 0.5 mg by mouth one time a day for schizophrenia and - To administer risperidone 1 mg by mouth at bedtime for schizophrenia. Review of Resident 28's Informed Consent dated 1/21/25, for risperidone 0.5 mg by mouth one time a day for schizophrenia and risperidone 1 mg by mouth at bedtime for schizophrenia, but the informed consent form was not signed by the physician. Further review of Resident 28's medical record failed to show an informed consent for the risperidone medication was obtained from the resident or her responsible party. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/24/25 at 1033 hours, an interview and concurrent medical record review for Resident 28 was conducted with RN 1. RN 1 verified the above findings. RN 1 stated the physician who ordered the medications obtained the consent, and the facility had to fax the informed consent to the physician's office. RN 1 reviewed Resident 28's medical record and was unable to find documentation the informed consent was obtained from the resident or their responsible party for the use of the risperidone medication. 49258 5. Medical record review for Resident 13 was initiated on 1/22/25. Resident 13 was readmitted to the facility on [DATE]. Review of Resident 13's H&P examination dated 4/30/24, showed Resident 13 had the capacity to understand and make decisions. Review of Resident 13's Order Summary Report showed the following physician's orders dated 4/29/24: - to administer trazodone 100 mg two tablets by mouth at bedtime for depression as manifested by inability to sleep; - to administer Zyprexa 15 mg one tablet by mouth at bedtime for schizoactive disorder (mental health condition) as manifested by paranoid delusion (false belief that someone is being threatened or mistreated); and - to administer bupropion hydrochloride extended release 200 mg one tablet by mouth two times a day for depression as manifested by withdrawal from activities of interest. Review of Resident 13's MAR for November 2024, December 2024 and January 2025, showed Resident 13 received the following: - trazodone medication from 11/1 to 11/30/24 at 21 hours, 12/1 to 12/31/24 at 2100 hours, and 1/1 to 1/21/25 at 2100 hours; - Zyprexa medication from 11/1 to 11/30/24 at 2100 hours, 12/1 to 12/31/24 at 2100 hours, and 1/1 to 1/21/25 at 2100 hours; and - bupropion hydrochloride extended release medication from 11/1 to 11/30/24 at 0900 hours and 1700 hours, 12/1 to 12/31/24 at 0900 hours and 1700 hours, 1/1 to 1/21/25 at 0900 hours and 1700 hours, and 1/22/25 at 0900 hours. Further review of Resident 13's medical record did not show documented evidence the informed consents for the trazodone, Zyprexa, and bupropion hydrochloride extended release medications were renewed six months after 5/1/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/24/25 at 1327 hours, a concurrent interview and medical record review for Resident 13 was conducted with RN 2. RN 2 stated the informed consents for psychotropic medications should be obtained initially once the physician's ordered it and it should be renewed every six months. RN 2 verified the consents for the trazodone, Zyprexa, and bupropion hydrochloride extended release medications were not renewed after 6 months. On 1/27/24 at 1445 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Resident 13. 51920 6. Medical record review for Resident 12 was initiated on 1/24/25. Resident 12 was readmitted to the facility on [DATE]. Review of Resident 12's Order Summary Report showed the following physician's orders: - dated 3/12/24, to administer Depakote 500 mg by mouth two times a day for mood stabilizer for labile mood m/b yelling and screaming without provocation - dated 10/7/24, to administer Seroquel 25 mg by mouth in the morning for schizoaffective disorder m/b paranoid delusions people are stealing his money - dated 10/7/24, to administer Seroquel 200 mg by mouth at bedtime for schizoaffective disorder m/b paranoid delusions people are stealing his money Review of the Informed Consent dated 6/4/24, showed Seroquel 50 mg and Depakote 500 mg. Further review of Resident 12's medical record did not show documented evidence the informed consents for the Seroquel and Depakote were renewed six months after 6/4/24. On 1/24/25 at 1041 hours, a concurrent interview and medical record review for Resident 12 was conducted with RN 2. RN 2 stated the informed consents for psychotropic medications should be obtained upon admission, with an increase in medication, and every 6 months. RN 2 verified the informed consents for the Seroquel and Depakote were not renewed after 6 months. 50787 7. Review of Resident 44's medical record was initiated on 1/24/25. Resident 44 was admitted on [DATE]. Resident 44's MDS asseesment showed the resident's BIMS score was 99 (indicates that the Brief Interview for Mental Status (BIMS) was incomplete. This can happen if the patient refused to participate, gave nonsensical answers, or the interview was stopped.). Review of Resident 44's Order Summary Report showed the following physician's orders: - dated 12/20/24, to administer Depakote ER 500 mg by mouth two times a day for mood stabilizer, (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 5/23/24, to administer fluvoxamine maleate 100 mg tablet at bedtime for depression, - dated 5/23/24, to administer olanzapine 5 mg tablet one tablet by mouth two times a day for schizophrenia (a mental illness that is characterized by disturbances in thought), and - dated 12/20/24, to administer risperidone oral tablet 2.5 mg two times daily for schizophrenia. Review of Resident 44's informed consents showed consents were obtained for the above medications from Resident 44's daughter on 5/24/24 Review of Resident 44's MAR for January 2025 showed: - Resident 44 was administered Depakote ER from 1/1/25 to 1/23/25. - Resdient 44 was administered fluvoxamine maleate from 1/1/25 to 1/23/25. - Resdient 44 was administered olanzapine 5 mg tablet from 1/1/25 to 1/23. - Resident 44 was administered risperidone from 1/1/25 to 1/23/25 Review of the facility's P&P on Informed Consent dated 4/2024 showed there is a requirement for the facility to renew informed consent every six months. The facility shall verify the informed consent has been obtained prior to the administration of psychotherapeutic medications. On 01/24/25 at 1333 hours, an interview and concurrent review of Resident 44's informed consent was conducted with RN 2. RN 2 showed informed consent dated 5/24/24, for the following medications: Depakote ER, fluvoxamine maleate, olanzapine, and risperidone. When asked for the renewal of the informed consents as per the facility's P&P, RN2 stated no, that's it for the consents. RN 2 acknowledged and verified Resident 44's consents were supposed to be renewed every six months. On 01/27/25 833 hours, interview with the DON was conducted. The DON acknowledged and verified Resident 44's consents were not renewed on the Depakote ER, fluvoxamine maleate, olanzapine and risperidone medications use.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50967 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one nonsampled resident (Resident 20) was free from the significant medication errors. * The facility failed to provide Resident 20's Zyprexa (antipsychotic medication) as ordered by the physician and accurately document the Zyprexa administration. This failure placed Resident 20 at risk for medical complications. Findings: Review of the facility's P&P titled Medication Administration dated 5/2019 showed the medications are administered in a safe and timely manner, and as prescribed. The medications must be administered in accordance with prescriber orders, including any required time frame. Review of the facility's P&P titled Physician Services and Orders dated 1/2017 showed: - Signed orders for drugs shall be transmitted to the issuing pharmacy within 48 hours of the receipt of the order; - The charge nurse or the DON shall place the order for all prescribed medications; and - Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy no less that three days prior to the last dosage being administered to assure that the refills are on hand. Medical record review for Resident 20 was initiated on 1/22/25. Resident 20 was admitted to the facility on [DATE]. Review of Resident 20's Order Summary Report showed a physician's order dated 1/17/25, to administer Zyprex 10 mg one tablet medication via GT at bedtime for schizoaffective disorder (a severe brain disorder in which people interpret reality abnormally) manifested by paranoid delusion (a thought process believed to be heavily influenced by anxiety or fear, often to the point of irrationality and delusion) with angry outburst from responding to internal stimuli. Review of Resident 20's MAR for January 2025 showed the following: - on 1/17 to 1/19/25 at 2100 hours, the section to document for the Zyprexa medication administration were blank. - on 1/20 and 1/21/25 at 2100 hours, the section to document for the Zyprexa medication administration were signed by the nurse. The MAR failed to show documentation to explain why the Zyprexa medication was not admistered from 1/7 to 1/19/25 at 2100 hours. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. On 1/22/25 at 1023 hours, a concurrent interview and medical record review was conducted with LVN 1. LVN 1 verified the missing documentations on Resident 20's MAR on 1/17 to 1/19/25 at 2100 hours. On 1/23/25 at 1030 hours, a follow-up interview was conducted with LVN 1. LVN 1 stated Resident 20 was in the facility between 1/17 to 1/19/25. Furthermore, LVN 1 stated the Zyprexa 10 mg medication was received last night by the night shift nurse. LVN 1 verified the Zyprexa 10 mg bubble pack was still complete and the label showed the medication was filled on 1/22/25 from the pharmacy. On 1/23/25 at 1059 hours, an interview was conducted with the Pharmacy Technician. The Pharmacy Technician was asked if the pharmacy received the new order for the Zyprexa 10 mg tablet medication and when was it delivered. The Pharmacy Technician stated the pharmacy received an order for the Zyprexa 10 mg on 1/20/25, however, the medication was not sent. The Pharmacy Technician further stated the pharmacy received another faxed order of Zyprexa on 1/22/25 at 1110 hours and medication was delivered on 1/22/25 at 2315 hours. b. On 1/23/25 at 1313 hours, an interview was conducted with LVN 2. LVN 2 was asked if she administered Resident 20's Zyprexa 10 mg on 1/17 to 1/19/25 at 2100 hours, and the reason for the missing documentations on the MAR. LVN 2 stated the medication did not arrive on 1/17/25 and she did not administer the Zyprexa medication. LVN 2 stated she documented on the nurse's progress notes the medication was not received. Furthermore, LVN 2 was asked if the Zyprexa 10 mg was available on 1/20 and 1/21/25. LVN 2 stated she worked on 1/21/25 and Resident 20's Zyprexa medication was not available. LVN 2 verified she signed the MAR without administering the medication. LVN 2 acknowledged it was a medication error and supposed to make sure medications were given as ordered. On 1/23/25 at 1457 hours, an interview was conducted with the DON. The DON stated if the medications were not received, the charge nurses or RN should follow up with the pharmacy. Furthermore, the DON stated it was unacceptable for the charge nurses to document in the MAR to show the medications were administered when the residents' medications were not available or on hand. On 1/7/25 at 1334 hours, an interview was conducted with DON and Administrator. The DON and Administrator verified and acknowledged above findings.

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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. 45064 Based on observation, interview, facility document review, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure proper storage of the medications for two of five Medication Cart (Medication Carts A and B) when: * The facility failed to ensure the orally administered medications were stored separate from externally used medications and supplies in Medication Cart A. * The facility failed to ensure Medication Cart B was not left unlocked and unattended by the licensed nurses while parked in the hallway. These failures had the potential to negatively impact the residents' well-being and opportunities for drug diversion or drug misuse. Findings: Reviewed of the facility's P&P titled Storage of Medications effective date 4/2008 showed the following: - Orally administered medications are kept separate from externally used medications. - Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. 1. On 1/23/25 at 1320 hours, a medication cart inspection for Medication Cart A was conducted with LVN 1. The following medications were observed stored in one compartment: - a box of loperamide HCL tablets (antidiarrheal medication); - a bottle of sodium chloride tablets (normal salt supplement); - Salonpas patches (topical pain medication); and - one tube of Refresh Celluvisc (lubricant eye gel). LVN 1 verified the above findings. LVN 1 further stated those medications should not be stored together because they were administered in different route. 39453 2. On 1/27/25 at 0901 hours, Medication Cart B parked in the hallway was observed unlocked and unattended. The facility staff members and residents were observed passing by. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/27/25 at 0909 hours, the DON and LVN 1 verified Medication Cart B was unlocked and unattended. LVN 1 stated she opened the cart and took the narcotic medications from Medication Cart B and forgot to lock it.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 39856 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the kitchen staff were competent in their position related duties when: 1. Two of 13 kitchen employees (Dietary Aides 2 and 3) were unable to correctly test the sanitizing solution used to sanitize the food preparation surfaces in the kitchen and sanitize the food preparation equipment washed in the manual ware washing sink. 2. One of 13 kitchen employees (Cook 1) did not know the correct cutting board to be use when preparing raw poultry. These failures posed the risk for exposure to unsafe food handling practices which could lead to food borne illness in the 94 vulnerable residents who received food prepared in the kitchen. Findings: Review of the facility's undated matrix showed 94 residents received food prepared in the kitchen. 1. Review of the facility's document titled Employee Evaluation Form dated 10/3/24, signed by the CDM and Dietary Aide (DA) 2 showed DA 2 met expectations in quality of work; work was completed accurately (few or no errors) efficiently and within deadlines with minimal supervision. Review of the facility's document titled Dietary Competency Evaluation dated 10/3/24, signed by the CDM and DA 2, did not include a competency evaluation on the testing of the sanitizing solution used to sanitize the food preparation surfaces. Review of the sanitizing solution test strip instructions located on the container of the sanitizing solution test strips showed to immerse the test strip in the sanitizing solution for ten seconds then compare the wet test strip to the color chart located on test strip container. On 1/21/25 at 1418 hours, an observation and concurrent interview was conducted with DA 2. DA 2 was asked to demonstrate how to test the sanitizing solution used to sanitize food preparation surfaces in the kitchen. DA 2 obtained a test strip, held it in the sanitizing solution for two seconds then compared the test strip to the color chart. The test strip read 150 parts per million (ppm), a measurement used to determine concentration of the sanitizing chemical. DA 2 was asked if 150 ppm was ok. DA 2 did not respond. DA 2 was asked to test the sanitizing solution a second time and hold the strip in the sanitizing solution for ten seconds. DA 2 inserted a clean test strip into the sanitizing solution for four seconds then compared the test strip to the color chart. The test strip read 150 ppm. DA 2 confirmed 150 ppm was not ok. On 1/23/25 at 0956 an interview was conducted with the CDM. The CDM was asked how he ensured the kitchen employees were competent in their job duties. The CDM stated he gave in-service training however the CDM confirmed he had not given in-service training on testing the sanitizing solution for kitchen staff. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/23/25 at 1020 hours, a telephone interview was conducted with the RD. The RD stated she was not involved in regular in-service training for the kitchen employees. a. Review of the facility document titled Employee Evaluation Form dated 8/6/24 signed by the CDM and DA 3 showed, DA 3 met expectations in quality of work; work was completed accurately (few or no errors) efficiently and within deadlines with minimal supervision. Review of the facility document titled Dietary Competency Evaluation dated 8/19/24 signed by the CDM and DA 3, did not include a competency evaluation on the manual dishwashing procedure. Review of the facility's job description titled Dishwasher signed by DA 3 on 8/19/18, showed General Duties and Responsibilities: wash and clean utensils as directed and perform dishwashing/cleaning procedures. Review of the facility document titled Record of Departmental In-service and Trainings, Three Compartment Washing dated 9/25/24, showed DA 3 was in attendance. On 1/21/25 at 1426 hours, an interview was conducted with DA 3 using the COTA as a translator and the CDM present. DA 3 was asked to describe the manual dishwashing procedure used in an emergency when the automatic dishwasher was not operable. DA 3 was not able to demonstrate or describe how to test the concentration of the sanitizing solution used to sanitize the dishes or what the correct concentration of the sanitizing solution should be. The CDM then asked DA 3 in English how to check the concentration of the sanitizing solution however DA 3 was not able to provide the correct information. On 1/21/24 at 1435 hours, an interview was conducted with the CDM. The CDM was asked if DA 3 had been trained on the manual dishwashing procedure. The CDM stated he provided an in-service in September and December of 2024. DA 3 attended the in-service in September 2024. The CDM was asked how he evaluated the employee's competency. The CDM stated he demonstrated the manual ware washing process and provided the process in writing in the appropriate language of the employee. The CDM confirmed he did not however, require a return demonstration from the employee on the manual dishwashing process to evaluate the employee's competency. On 1/23/25 at 1020 hours, a telephone interview was conducted with the RD. The RD stated she was not involved in regular in-service training for the kitchen employees. 2. Review of the facility document titled Dietary Competency Evaluation dated 10/4/24 and signed by the CDM and [NAME] 1, showed [NAME] 1 was competent in demonstrating preparation of food. Review of the facility's job description titled [NAME] signed by [NAME] 1 on 8/5/18, showed General Duties and Responsibilities: Prepare food in accordance with sanitary regulations and as well as with our policies and procedures. Review of the facility document undated titled, US Cutting Board Color Chart showed, Red - raw beef, pork, lamb, and other types of raw meat; Yellow - raw poultry, such as chicken, turkey and duck; Blue - raw fish, shellfish, and other seafood products; [NAME] - dairy and baked goods; [NAME] - fruits, vegetables and salads; [NAME] - cooked meat, such as roast, beef or ham. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the initial inspection of the kitchen on 1/21/25 at 0800 hours, an observation of [NAME] 1 and concurrent interview was conducted with Diet Aid 1. [NAME] 1 was observed using a red cutting board for raw poultry. When asked if it was ok to use a red cutting board for raw poultry, [NAME] 1 did not respond. DA 1 confirmed raw poultry should be prepared using a yellow cutting board. On 1/23/25 at 0956 hours, an interview was conducted with the CDM. The CDM was asked how he ensured the kitchen employees were competent in their job duties. The CDM stated he gave in-service training however the CDM confirmed he had not given in-service training on the proper use of cutting boards in 2024. On 1/23/25 at 1020 hours, a telephone interview was conducted with the RD. The RD stated she was not involved in regular in-service training for the kitchen employees.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39856 Based on observation, interview, and facility document review, the facility failed to ensure the nutritional needs were met for two of 82 nonsampled residents (Residents 11 and 70) who received a vegetarian diet preference when the lunch meal served provided nine grams of protein vs 28 grams of protein per the regular menu. This failure posed the threat of the nutritional needs; specifically the protein needs for Residents 11 and 70 to not be met which could lead to medical complications. Findings: 1. According to the California Health and Safety Code Section 1265.10: Effective 1/1/19, the skilled nursing facilities must make available wholesome, plant-based meals of such variety as to meet the needs of patients in accordance with their physicians' orders. Review of the facility's document titled Cooks Spreadsheet showed the following: Week 4 Wednesday dated 1/22/25, showed for the lunch meal, four ounces Old Fashioned Meatloaf for the entree for regular diets. The lunch meal entree served for 1/22/25, was equivalent to 28 grams (gm) of protein. Review of the facility's document titled Recipe: Grilled Cheese Sandwich Week 4 Tuesday undated, showed one sandwich was equivalent to two ounces of protein. The Grilled Cheese Sandwich recipe showed Do not use American Cheese. Directions: 1) Make sandwiches: two ounces of cheese per sandwich. Review of the nutritional information for the American Cheese used to make the Grilled Cheese Sandwiches showed one slice of cheese provided 60 calories and three grams of protein. Medical record review for Residents 11 and 70 was intiated on 1/22/25. * Review of the medical record for Resident 11 showed Resident 11 was admitted to the facility on [DATE] with medical diagnoses which included vitamin D deficiency and hypocalcemia (low blood calcium). Further review of the medical record showed a physcian's order dated 10/10/24, for a Regular diet, regular texture no meat, no fish diet. During the lunch meal tray line service on 1/22/25 at 1144 hours, the following was observed: Res 11's lunch meal tray consisted of one grilled cheese sandwich, peas, orange juice and cranberry juice. * Review of the medical record for Resident 70 showed Resident 70 was admitted to the facility on [DATE] with medical diagnoses which included severe protein calorie malnutrition and pulmonary (lung) disease. Further review of the resident's medical record showed a physician's order dated 1/6/25, for a Vegetarian Lacto (dairy products) diet, regular texture. During the lunch meal tray line service on 1/22/25 at 1144 hours, the following was observed: (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 70's lunch meal tray consisted of one grilled cheese sandwich, peas, jello, milk, and juice. On 1/22/25 at 1200 hours, an interview was conducted with [NAME] 2. [NAME] 2 was asked how he prepared the grilled cheese sandwiches for the lunch meal. [NAME] 2 stated he used three slices of American cheese for each grilled sandwich which was equivalent to nine grams of protein. On 1/22/25 at 1550 hours an interview was conducted with [NAME] 3 and the CDM. When asked if the facility provided a vegetarian diet, [NAME] 3 stated he provided meal entrees such as a grilled cheese sandwich, cheese ravioli, grilled quesadilla or tofu. [NAME] 3 confirmed the menu spreadsheet did not include a vegetarian diet. When asked how he determined the appropriate portion size for a vegetarian diet, [NAME] 3 confirmed there were no portion sizes for vegetarian diets available. On 1/23/25 at 1020 hours, a telephone interview was conducted with the RD. The RD stated the facility did not have a vegetarian menu but stated ideally there should be a menu and a therapeutic spreadsheet with appropriate portions sizes available. The RD confirmed the facility served meal entrees such as grilled cheese sandwiches or tofu for vegetarian diets. The RD further stated that vegetarian meal entrees should be nutritionally equivalent to the regular menu entree.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50787 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen as evidenced by: * The facility failed to ensure the correct cutting board was used for raw poultry. * The facility failed to ensure the sanitizing solution used to sanitize food preparation surfaces was the proper concentration. * The facility failed to ensure kitchen equipment and utensils were clean . * The facility failed to ensure kitchen equipment and utensils were air dried . * The facility failed to ensure maintenance tools were stored in a sanitary manner . These failures had the potential to cause bloodborne illness in a medically vulnerable resident population of 94 who consumed food prepared from the kitchen. Findings: Review of the facility's undated matrix showed 94 of 106 residents received food prepared in the kitchen. 1. According to US Food and Drug Administration (USFDA) Food Code Section 3-302.11 Packaged and Unpackaged Food - Separation, Packaging, and Segregation. (A) Food shall be protected from cross contamination by: (2) Except when combined as ingredients, separating types of raw animal foods from each other such as beef, fish, lamb, pork, and poultry during storage, preparation, holding, and display by: (a) Using separate equipment for each type. Review of the facility's document titled US Cutting Board Color Chart undated showed Red - raw beef, pork, lamb, and other types of raw meat; Yellow - raw poultry, such as chicken, turkey and duck; Blue - raw fish, shellfish, and other seafood products; [NAME] - dairy and baked goods; [NAME] - fruits, vegetables and salads; [NAME] - cooked meat, such as roast, beef or ham. On 1/21/25 at 805 hours, during the initial inspection of the facility's kitchen with Dietary Aide (DA) 1, [NAME] 1 was observed cutting raw chicken using a red cutting board. [NAME] 1 was asked if it was okay to use the red cutting board for raw chicken, [NAME] 1 did not answer. DA 1 verified a yellow cutting board must be used for the raw poultry. 2. According to the USFDA Food Code Section 3-304.14 Wiping Cloths, Use Limitation. (B) Cloths in-use for wiping counters and other surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under S 4-501.114. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's P&P titled Quaternary Ammonium Log Policy dated 2018 showed . the quaternary solution will be replaced when the reading is below 200 parts per million (ppm). On 1/21/25 at 1419 hours, DA 2 was asked to test the sanitizing solution in the sanitizing bucket. DA 2 used the sanitizing test strip to check the concentration of the sanitizing solution. The sanitizing solution test strip showed the concentration of the sanitizing solution was 150 ppm. DA 2 confirmed the concentration of the sanitizing solution was not the correct concentration. On 1/23/25 at 956 hours, an interview was conducted with the CDM. The CDM stated the sanitizing solution should be changed every four hours and as needed. 3. According to USFDA Food Code 2022 Section 4-601.11Equipment, Food Contact Surfaces, Non- Food Contact Surfaces and Utensils. (A) Equipment, food- contact surfaces and utensils shall be clean to sight and touch. On 1/21/24 at 805 hours, during the initial tour of the kitchen with DA 1, the following were observed: - a blender had a brown residue on the inside of the pitcher; - a microwave had food residue on the turntable and inner part of the microwave door; - a toaster with a thick brown, greasy build up; and - a robocoupe (a device used to chop and puree food), blade and bearing assembly had a brown residue. DA 1 confirmed the above findings. 4. According to the USFDA Food Code 2022 Annex, Section 4-901.11 Equipment and Utensils, Air-Drying Required. Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. Cloth drying of equipment and utensils is prohibited to prevent the possible transfer of microorganisms to equipment or utensils. On 1/21/24, at 0805 hours, during the initial tour of the kitchen with DA 1, the following were observed - six steam table pans stacked and stored wet, - the robot coupe, was stored wet with the top on, and - the blender was stored wet with the top on . DA 1 confirmed the above findings. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. According to the USDA Food Code 2022 section 6- 501.113 Storing Maintenance Tools. Maintenance tools such as brooms, mops, vacuum cleaners, and similar items shall be: A Stored so that they do not contaminate food, equipment, utensils. On 1/21/25 at 805 hours, during the initial kitchen inspection with DA 1, two brooms were observed on the floor, DA1 verified and moved the brooms to the designated storage by the wall. On 01/23/25 1430 hours, a concurrent interview was conducted with the Administrator, Assistant Administrator, DON, and CDM. The Administrator, Assistant Administrator, DON and CDM were informed and verified the above findings.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 39856 Based on observation, interview, and facility P&P review, the facility failed to ensure food brought to the facility from family members or visitors was stored, prepared and safe food handling practices were followed. This failure had the potential for unsafe food handling which could lead to food borne illness in the 94 residents receiving an oral diet who resided in the facility. Findings: Review of the facility P&P titled Food and Liquids from Outside Sources or Other Than the Dietary Department revised 7/2019 showed the food and liquids brought in by visitors for the residents is discouraged due to problems of infection control and conflicts between diets and consistency .Visitors are discouraged from bringing in potentially hazardous foods, i.e. meat, fish, eggs, custards, milk products, etc. If such foods are brought to the resident, they should be consumed immediately and not shared with other residents within the facility .Food items brought into the facility for residents cannot be reheated or stored. They are to be consumed or discarded. On 1/21/25 at 1115 hours, an interview was conducted with RN 1. When asked about how the food brought to the facility for the residents from the visitors was handled, RN 1 stated the food from the visitors could be stored for 24 hours. RN 1 was asked if she had received training on safe food handling. RN 1 stated she had not received training on safe food handling recently. RN 1 was asked if the facility allowed food from the resident's visitors to be heated. RN 1 stated there was a microwave at Nursing Station 1. On 1/21/25 at 1121 hours, an interview was conducted with RN 4 at Nursing Station 1. RN 4 confirmed the food from the resident's visitors could be heated in the microwave located at Nursing station 1. The microwave at Nursing Station 1 was observed to have a brown burned residue on the inside top of the microwave. RN 4 stated she would have the microwave removed. RN 4 was asked if the information on safe food handling was provided to the visitors. RN 4 stated she was not aware of any information on safe food handling for the visitors, but she would check with the Admissions Coordinator. On 1/21/25 at 1127 hours, an interview was conducted with the DSD. The DSD was asked if she had given an in-service training to the staff members on safe food handling. The DSD stated she would check her records. On 1/21/25 at 1130 hours, an interview was conducted with the Admission Coordinator. When asked if he was aware of any information on safe food handling provided to the residents or visitors, the Admission Coordinator stated he was not aware of any. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/25 at 0854 hours, an interview was conducted with the DON. The DON was asked to explain the process when the visitors brought food for the residents from the outside. The DON stated when the visitors brought food for the residents from the outside, the residents were encouraged to finish the food right away however, there was a refrigerator where the food could be stored until the following day. The DON added no sharing of food with other residents was allowed. When asked about the staff member education of the safe food handing, the DON stated the DSD and Infection Preventionist (IP) gave in-service training on safe food handling. The DON was asked how visitors were educated on safe food handling. The DON stated she was not aware how the visitors were educated on the safe food handling. On 1/22/25 at 0921 hours, the DON confirmed the facility did not provide any information in writing to the visitors on the safe food handling. On 1/22/25 at 0938 hours, an interview was conducted with the IP. The IP was asked if he had provided any education for the facility staff member on the safe food handling. The IP stated he could not recall but would check his education records. On 1/22/25 at 1107 hours, the IP confirmed he had not provided the facility staff members with the education on the safe food handing.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on interview and medical record review, the facility failed to ensure the medical record was complete and accurately maintained for one of 24 final sampled residents (Resident 8). * Resident 8's POLST and Advance Directive Acknowledgement form failed to show documentation as to whether Resident 8 had formulated an advance directive. This failure had the potential for the resident's wishes specific to health care interventions not being honored. Findings: Medical record review for Resident 8 was initiated on 1/21/25. Resident 8 was admitted to the facility on [DATE]. On 1/22/25 at 1554 hours, an interview and concurrent medical record review was conducted with the SSD. Review of Resident 8's POLST, Section D (advance directive) dated 10/14/20, failed to show documentation as to whether Resident 8 had formulated an advance directive. Review of Resident 8's Advance Directive Acknowledgement form dated 8/22/24, failed to show documentation as to whether Resident 8 had formulated an advance directive. The SSD verified the findings.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51539 Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services for one of one final sampled resident reviewed for hospice services (Resident 49). * The facility failed to ensure Resident 49 received the hospice care visits three times a week by the Certified Home Health Aid and one to three visits a week from the Skilled Nurse. * The facility failed to assign a designated hospice coordinator for Resident 49. These failures posed the risk for delays in the communication between the hospice provider and the facility which may affect resident care. Findings: Review of the facility's P&P titled Hospice Care revised 9/2018 showed the following: - The facility is responsible for ensuring that hospice services meet professional standards and the timelines of the services. - The facility must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the facility staff and hospice staff. Medical record review for Resident 49 was initiated on 1/22/25. Resident 49 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 49's physician's order dated 10/2/24, showed resident was admitted to Hospice Agency 1 under routine level of care with primary diagnosis of senile degeneration of brain, unspecified. Review of Resident 49's Physician Order Summary Report dated 12/31/24, showed an order for the Hospice Certified Home Health Aide (CHHA) visits three times a week and Hospice Skilled Nurse (SN) visits one to three times a week and as needed for change of condition. Review of Resident 49's Visit Record and Vital Signs Sheet from Hospice Agency 1 showed the following visits were conducted by the hospice nurses: - During the week of 9/29/24 to 10/5/24, there were CHHA visits on 10/2 and on 10/3/24, instead of three visits as ordered. There was no documented evidence of the SN visit during this week. - During the week of 10/6/24 to 10/12/24, there were CHHA visits on 10/9 and on 10/12/24 instead of three visits as ordered. There was no documented evidence of the SN visit during this week. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- During the week of 10/13/24 to 10/19/24, there were no visits from the CHHA and SN. - During the week of 10/20/24 to 10/26 24, there was only one visit conducted by CHHA on 10/23/24, instead of three visits as ordered. There was no documented evidence of the SN visit during this week. - During the week of 10/27/24 to 11/2/24, there was only one visit conducted by CHHA on 10/30/24, instead of three visits as ordered. There was no documented evidence of the SN visit during this week. - During the week of 11/3/24 to 11/9/24, there was no CHHA visit conducted during this week. - During the following weeks there were only one visit a week conducted by the CHHA: week of 11/10/24 to 11/16/24, week of 11/24/24 to 11/30/24, week of 11/24/24 to 11/30/24, week of 12/8/24 to 12/14/24, and week of 12/22/24 to 12/28/24. In addition, there was no documented evidence of the SN visit was conducted to the resident. On 1/23/25 at 1417 hours, an interview and concurrent Hospice Visit Record and Vital Signs Sheet review was conducted with the DON. The DON verified the visitation logs have not been reviewed and the facility did not have a designated Hospice Coordinator to follow up with the plan for the hospice visitations for Resident 49. On 1/23/25 at 1429 hours, an interview and concurrent Hospice Visit Record and Vital Signs Sheet review was conducted with the MDS Coordinator. The MDS Coordinator verified that the facility did not have a Hospice Coordinator and stated the facility needed to have a Hospice Coordinator to make sure the plan for the visitations were conducted by the hospice company.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49258 Based on observation, interview, and facility P&P review, the facility failed to ensure the appropriate infection control practices were implemented as evidenced by: * The employees and residents' personal belongings were in the laundry room's clean folding area. * The facility failed to clean the spoon container on the Medication Carts for two of five medication carts inspected (Medication Carts B and C). These failures had the potential for spread of infection. Findings: Review of the facility's P&P titled Infection Control Program System revised 1/2023 showed the personnel must handle, store, process, and transport linens to prevent the spread of infection. Review of the facility's P&P titled Policy for Laundry - Nursing P&P Manual revised 8/2016 showed the linens are handled, stored, processed, and transported in such a manner as to prevent the spread of infection. 1. On 1/27/25 at 1245 hours, a concurrent observation of the laundry room and interview was conducted with the Environmental Services Director (ESD). The following items were observed in the clean folding area: - a large pink purse; - a white cellphone charger; - a plastic botttle of lotion; - an eye goggle; - two plastic bottled water; - a black remote control; and - two reading eye glasses. The ESD verified the above findings. The ESD stated the two reading eye glasses and remote control were mixed from the soiled linens which were taken out from the residents' rooms. The ESD was unable to answer when asked if the reading eye glasses and remote control were sanitized since it came from the soiled linens. The ESD stated the rest of the items were owned by the laundry staff. The ESD stated these items should not be in the clean folding area because it could cause contamination to the clean clothes and linens used by the residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/27/25 at 1347 hours, a interview was conducted with the IP. The IP stated the laundry room's clean folding area should be free of any employees and residents' personal belongings to prevent spread of infection and contamination of linens. The IP was informed and acknowledged the above findings. 45064 2. Review of facility's P&P titled Storage of Medications effective 4/2008 showed the medication storage areas are kept clean. On 1/22/25 at 1200 hours, an observation of Medication Carts B and C was conducted. Spoon containers used for medication administration on the side of the Medication Carts were observed as follows: - Medication Cart B's spoon container had some parts of it with broken pieces of plactic and - Medication Cart C spoon's container, the middle compartment was cracked and was taped. In addition, Medication Cart B and C's spoons containers was observed with dirt and brown dry substance on the outside and inside. On 1/22/25 at 1210 hours, an interview with an IP, who verified Medication Cart B and C spoon container were not clean, broken and has tape on them. The IP further stated the spoons were used to give medications, and the spoon container should be clean to prevent the spread of infection.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 50787 Based on observation, interview, and facility document and facility's P&P review, the facility failed to ensure the essential equipment was maintained in proper working order when: * The ice machine manufacturer's guidelines for cleaning and sanitizing were not followed. * The microwave located on Station 1 was not maintained in a safe operating condition. * Two medication refrigerators and one specimen refrigerator were observed with ice buildup. These failures had the potential for equipment hazards or unsafe practices which could affect the residents' well-being in the facility. Findings: 1. Review of the facility's P&P titled Cleaning the Ice Machine revised date of 4/2022 showed the ice machine shall be cleaned for maintenance of sanitary conditions in order to prevent food contamination and the growth of disease- producing organism and toxins. The ice machine shall be cleaned in accordance with the manufacturer's requirements. Review of the [Manitowoc] ice machine model 1-300/420/620 manufacturer's instructions located on the inside panel of the ice machine cover showed in part, the following: - Step 5- Remove parts for the cleaning. - Step 6- Mix a solution of cleaner and lukewarm water .one gallon water to 16 ounces(oz) cleaner. - Step 7- Use half of the cleaner mixture to clean all components . Rinse all components with clean water. Sanitizing Procedure: - Step 9- Mix a solution of two ounces sanitizer with three gallons of lukewarm water. - Step 10- Use half of the sanitizer/water solution to sanitize all removed components. Use a spray bottle to liberally apply the solution to all the surfaces of the removed parts or soak the removed parts (top, bottom, and sides), bin or dispenser. Do not rinse parts after sanitizing. On 1/21/25 at 907 hours, an interview was conducted with the Maintenance Director. The Maintenance Director stated the facility's ice machine was cleaned monthly by the facility's maintenance staff and annually by the company and the ice machine manufacturer instructions were followed. The Maintenance Director further stated to clean the ice machine, he used five ounces of the descaler (a chemical solution that removes mineral deposits, or scale, from surfaces) mixed with one gallon of water. To sanitize the ice machine, he used one gallon of water mixed with three ounces of descaler. However, the Maintenance Director's methods of cleaning and sanitizing were not in accordance with the manufacturer's guidelines. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the facility's P&P titled Sanitation dated 2018 showed all utensils, counters, shelves and equipment shall be kept clean, maintained and in good repair and shall be free from breaks, corrosions, open seam, cracks and chipped areas. On 1/21/25 at 1121 hours, an interview regarding heating food brought for the residents from the outside and concurrent inspection was conducted with RN 1. RN 1 stated the facility used the microwave located at Station 1 to heat food brought from the outside for the residents. The microwave was observed to have charred, burnt interior. RN1 confirmed the finding and stated she would have maintenance removed the microwave right away. On 1/21/25 at 1145 hours, an interview with the Maintenance Director was conducted on how the maintenance department was notified of any faulty equipment. The Maintenance Director stated there was a maintenance logbook in the nurses' stations or they called directly. The Maintenance Director further stated, they just called me now and I removed it when asked about the microwave in Station 1. On 1/23/25 at 1430 hours, an interview was conducted with the Administrator, Assistant Administrator, DON and CDM regarding the above findings. The Administrator, Assistant Administrator, DON and CDM acknowledged and verified the above findings. 35346 3.a. On 01/22/25 at 1022 hours, a medication storage inspection for Station 1 was conducted with the DON. The ice buildup was observed on the back wall of medication refrigerator in Station 1. The DON verified the finding. b. On 01/22/25 at 1046 hours, a medication storage inspection for Station 3 was conducted with the DON. The ice buildup was observed in the freezer compartment of medication refrigerator in Station 3. The DON verified the finding. c. On 01/23/25 at 0814 hours, during an inspection of the specimen refrigerator with the Infection Preventionist, the freezer compartment of the specimen refrigerator was observed with ice buildup. The Infection Preventionist verified the finding.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49258 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the residents' entrapment assessments were complete and the measurements were recorded during the bed inspection when identifying areas of possible entrapment with the use of side rails for four of four sampled residents (Residents 5, 13, 29, and 37) reviewed for side rails use. The facility also failed to ensure all the beds in the facility were regularly inspected. These failures had the potential to negatively impact the residents resulting in possible entrapment, serious injury, and death. Findings: According to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, the term entrapment describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. The seven areas in the bed system where there is a potential for entrapment are: - Zone 1: within the rail; - Zone 2: under the rail, between the rail supports or next to a single rail support; - Zone 3: between the rail and the mattress; - Zone 4: under the rail, at the ends of the rail; - Zone 5: between split bed rails; - Zone 6: between the end of the rail and the side edge of the head or foot board; and - Zone 7: between the head or foot board and the mattress end. Review of the facility's P&P titled Bed Safety revised 8/2018 showed to try to prevent death/injury from the beds and related equipment (including frame, mattress, side rails, grab bars, headboard, footboard, and bed accessories), the facility shall promote the following approaches: - Inspection by maintenance staff of all beds and related equipment as part of the facility's regular bed safety program to identify any risks or problems including potential entrapment risks; - Review to ensure that gaps in the bed system do not present a hazard to the resident due to the resident's height and/or weight or due to the resident's movement or bed position; and (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Ensure that if a grab bar or bed side rails are to be utilized those are properly installed using the manufacturer's instructions and other pertinent safety guidance to ensure proper fit (e.g. avoid bowing, ensure proper distance from the headboard and footboard, etc.). Review of the facility's P&P titled Side Rails or Bed Rails revised 8/2018 showed if a bed or side rail is used even for episodic use, the facility will make sure that it is installed correctly, used correctly, and maintained. The resident will be assessed for the risk of entrapment from the bed rails prior to its installation and the facility will make sure that the bed's dimensions are appropriate for the resident's size and weight. Review of the facility's P&P titled Side Rail or Bed Rail Assessment Guidance to Reduce Entrapment revised 8/2018, showed the facility had to assess the resident's risk for entrapment prior to the installation of side rails or bed rails to ensure the bed dimensions are appropriate for the resident's size and weight. The facility will assess the resident's risk for entrapment for the use of a grab bar using the facility's grab bar assessment. A concurrent observation, medical record review, and facility document review for Residents 5, 13, 29, and 37 showed the residents' bed entrapment assessments were not completed or the bed inspection gap measurement for Zone 2 was recorded. For example: 1. During the initial tour of the facility on 1/21/25 at 0958 hours, Resident 13 was observed awake and sitting in the wheelchair beside the bed. The bed was observed with bilateral upper side rails elevated. Resident 13 stated he grabbed the side rails during turning or when he was getting out of the bed. Medical record review for Resident 13 was initiated on 1/22/25. Resident 13 was readmitted to the facility on [DATE]. Review of Resident 13's H&P examination dated 4/30/24, showed Resident 13 had the capacity to understand and make decisions. The H&P examination also showed Resident 13 had a significant diagnosis of morbid obesity. Review of Resident 13's MDS dated [DATE], showed Resident 13 required partial to moderate assistance for bed mobility. Further review of Resident 13's medical record failed to show documented evidence an entrapment assessment was completed prior to installation of the side rails. On 1/22/25 at 0934 hours, an observation and concurrent interview was conducted with Resident 13. Resident 13 was observed awake and lying in the bed with the bilateral upper side rails elevated. Resident 13 stated he had been using the side rails for a long time and not just a month ago. Resident 13 further stated he needed the side rails to grab when he turned from side to side or when he was getting out of bed. On 1/22/25 at 1553 hours, a concurrent observation and interview was conducted with CNA 5. CNA 5 was observed leaving Resident 13's room. CNA 5 stated she just assisted Resident 13 with the bedpan. CNA 5 stated when Resident 13 was in bed, the bilateral side rails were always elevated. CNA 5 further stated Resident 13 grabbed on the side rails when being assisted with turning. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/23/25 at 1418 hours, a concurrent interview and medical record review for Resident 13 was conducted with LVN 1. LVN 1 stated an entrapment risk assessment should be completed prior to installation of side rails. LVN 1 stated the maintenance department was responsible for installing the side rails and measuring the gaps in bed. LVN 1 verified no assessment for the risk of entrapment from elevated side rails was done for Resident 13 prior to installation. 2. During the initial tour of the facility on 1/21/25 at 0855 hours, Resident 29 was observed awake and lying in the bed with the bilateral upper side rails elevated. Resident 29 stated she grabbed on the side rails when being turned for care provided or when she needed to get in or out of the bed. Medical record review for Resident 29 was initiated on 1/21/25. Resident 29 was readmitted to the facility on [DATE]. Review of Resident 29's H&P examination dated 10/25/24, showed Resident 29 had the capacity to understand and make decisions. The H&P also showed Resident 29 had a diagnosis of left hip fracture status post left hip replacement. Review of Resident 29's MDS dated [DATE], showed Resident 29 required partial to moderate assistance for bed mobility. Review of Resident 29's Order Summary Report showed a physician's order dated 10/28/24, for grab bars on both sides of the bed as enabler for turning/repositioning due to osteoporosis (a condition in which bones become weak and brittle)/rheumatoid arthritis (a chronic inflammatory disorder that affects the joints). Review of Resident 29's Bedrail/Grab bar use and Entrapment Risk Evaluation dated 10/28/24, showed the following: - The grab bars were requested by the resident, and the resident demonstrated the ability to use the grab bars; - The possible risks of entrapment were discussed, and verbalized understanding and agreement for continued use. - The Entrapment Zones 1 to 4, and the boxes for yes were checked off; and - The IDT recommended bilateral grab bars for enabler, turning/repositioning on bed. Review of Resident 29's Informed Consent for the Use of Anything Attached to a Bed dated 10/28/24, showed if a bed rail or siderail is used, the facility will make sure that it is installed correctly, used correctly and maintained. The resident will be assessed for entrapment from the bedrails/side rails prior to their installation and the facility will make sure that the bed's dimensions are appropriate for the resident's size and weight. Review of Resident 29's plan of care showed a care plan problem dated 10/28/24, to address the use of grab bar as an enabling device that does not limit freedom of movement. The approach plan included to assess the resident for risk for entrapment prior to installation, ensure bed dimensions appropriate for the resident's size and weight, and maintenance to check grab bars monthly. (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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/25 at 1041 hours, a concurrent observation of Resident 29 and interview with CNA 4 was conducted. Resident 29 was transferring from the wheelchair to the bed and being assisted by CNA 4. Resident 29 was observed grabbing to the right grab rail. CNA 4 stated Resident 29 had always have the side rails. CNA 4 stated Resident 29 held on the rails during repositioning or when she was getting out or in the bed. On 1/23/25 at 1446 hours, a concurrent interview and medical record review for Resident 29 was conducted with RN 3. When asked about the entrapment assessment related to the use of grab bars, RN 3 stated the CNAs could conduct the assessment to the make sure the resident was safe in using and really in need of the grab bars. RN 3 stated the licensed nurses would verify the assessment as well. When asked about the bed evaluation of Zones 1 to 4 marked yes in the evaluation form, RN 3 stated the maintenance staff was the one who was filling up the sections for Zones 1 to 4. On 1/24/25 at 1225 hours, a concurrent interview and facility document review for Residents 13 and 29 was conducted with the Environmental Services Director (ESD). The ESD stated the maintenance department was responsible for the monthly bed inspection of all the beds in the facility, where they checked the whole bed, bed functionality, frame, bed control, and grab bars. The ESD stated the maintenance department also installed the grab bars. When asked what was used to measure the entrapment zones on each bed, the Environmental Services Director showed a piece of wood marked with different measurements. When asked to show the documentation of the results of bed inspection including the entrapment assessment, the ESD showed the Siderail or Bedrail Assessment Guidance to Reduce Entrapment forms. Review of the Siderail or Bedrail Assessment Guidance to Reduce Entrapment form for November 2024 showed the following: - Resident 13's bed was inspected on 11/18/24. The form showed Zones 1, 3, and 7, and frame were marked ok, and Zones 2, 4, 5, and 6 were marked n/a. - Resident 29's bed was inspected on 11/18/24. The form showed Zones 1, 3, and 7, and frame were marked ok, and Zones 2, 4, 5, and 6 were marked n/a. Review of the Siderail or Bedrail Assessment Guidance to Reduce Entrapment form for December 2024 showed the following: - Resident 13's bed was inspected on 12/18/24. The form showed Zones 1, 3, and 7, and frame were marked ok, and Zones 2, 4, 5, and 6 were marked n/a. - Resident 29's bed was inspected on 12/18/24. The form showed Zones 1, 3, and 7, and frame were marked ok, and Zones 2, 4, 5, and 6 were marked n/a. Review of the Siderail or Bedrail Assessment Guidance to Reduce Entrapment form for January 2025 showed the following: - Resident 13's bed was not inspected. - Resident 29's bed was inspected on 1/20/25. The form showed Zones 1, 2, 3, 4, and 7, and frame were marked ok and Zones 5 and 6 were marked n/a. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555520	A. Building B. Wing	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leisure Court Nursing Center	1135 Leisure Court Anaheim, CA 92801

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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ESD verified the above findings. The ESD stated the entrapment assessment was conducted when the resident was not in the bed. The ESD stated they only marked ok when the bed passed the inspection, and n/a or not applicable. The ESD verified Zone 2 should have been checked. When asked about the other rooms that were marked with vertical lines, the ESD stated those were the rooms with beds without grab bars but was not able to explain why those rooms were marked with vertical lines. The ESD was not able to show documented evidence of the regular inspection of the beds without grab bars. On 1/27/24 at 1445 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 39453 3. On 1/21/25 at 0900 hours, during the initial tour of the facility, Resident 37 was observed in bed with bilateral grab rails elevated. Resident 37 stated she used the grab rails when turning and repositioning during incontinence care. Medical record review for Resident 37 was initiated on 1/30/25. Resident 37 was readmitted to the facility on [DATE]. Review of Resident 37's MDS dated [DATE], showed Resident 37 was cognitively intact, with impairment to the upper extremities, and required partial/moderate assistance for mobility. Review of Resident 37's Bedrail/ Grab bar use and Entrapment Risk Evaluation dated 1/3/25, showed the following: - The grab bars were requested by the resident, and the resident demonstrated the ability to use the grab bars; - The possible risks of entrapment were discussed, and verbalized understanding and agreement for continued use. - The Entrapment Zones 1 to 4, and the boxes for yes were checked off; and - The IDT recommended bilateral grab bars for bed mobility/repositioning. Review of Resident 37's Informed Consent for the Use of Anything Attached to a Bed dated 1/3/25, showed if a bed rail or side rail is used, the facility will make sure that it is installed correctly, used correctly and maintained. The resident will be assessed for entrapment from the bed rails/[NAME] ails prior to their installation and the facility will make sure that the bed's dimensions are appropriate for the resident's size and weight. Review of Resident 37's Order Summary Report showed a physician's order dated 1/3/25, to provide grab bars on bilateral sides of the bed as enabler for bed mobility, turning and repositioning secondary to generalized weakness. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 37's plan of care showed a care plan problem dated 1/3/25, addressing the use of grab bar as an enabling device that does not limit freedom of movement. The approach plan included to assess the resident for risk for entrapment prior to installation, ensure bed dimensions appropriate for the resident's size and weight, and for the maintenance to check grab bars monthly. On 1/22/25 at 1215 and 1544 hours, and 1/23/25 at 0835 hours, Resident 37 was observed in bed with bilateral grab rails elevated. On 1/23/25 at 0932 hours, an interview was conducted with CNA 3. When asked about Resident 37's use of bed rails, CNA 3 stated Resident 37 required extensive assist with mobility, but she could hold on to the grab bars when turning. On 1/23/25 at 1351 hours, an interview and concurrent medical record review for Resident 37 was conducted with RN 3. When asked about the entrapment assessment related to the use of grab bars, RN 3 stated the CNAs conducted the assessment to the make sure the resident was safe in using the grab bars. RN 3 stated, if there are concerns, then it will be delegated to the charge nurses, or if there was a problem, such as when the resident was tired from dialysis and could not grab the rails, then the CNAs would have to report to the charge nurse. When asked about the bed evaluation of Zones 1 to 4 marked yes in the evaluation form, RN 3 stated the bed evaluation was self-explanatory. When asked to elaborate, RN 3 was not able to identify and explain the zones of entrapment, specifically Zones 1 to 4. RN 3 stated RN 1 checked the bed and completed the grab bar evaluation form. RN 3 stated was not shown how to do the bed evaluation. On 1/24/25 at 1225 hours, a concurrent interview and facility document review for Resident 37 was conducted with the ESD. The ESD stated the maintenance department was responsible for the monthly bed inspection of all the beds in the facility, where they checked the whole bed, bed functionality, frame, bed control and the grab bars. The EDS stated the maintenance department also installed the grab bars. When asked what was used to measure the entrapment zones on each bed, the Environmental Services Director showed a piece of wood marked with different measurements. When asked to show the documentation of the results of bed inspection including the entrapment assessment, the Environmental Services Director showed the Siderail or Bedrail Assessment Guidance to Reduce Entrapment forms. Review of the Siderail or Bedrail Assessment Guidance to Reduce Entrapment form for November 2024 showed Resident 37's bed was inspected on 11/18/24. The form showed Zones 1, 3, and 7, and frame were marked ok, and Zones 2, 4, 5, and 6 were marked n/a for Resident 37's bed. Further review of the form showed other beds were left blank. Review of the Siderail or Bedrail Assessment Guidance to Reduce Entrapment form for December 2024 showed Resident 37's bed was inspected on 12/18/24. The form showed Zones 1, 3, and 7, and frame were marked ok, and Zones 2, 4, 5, and 6 were marked n/a for Resident 37's bed. Further review of the form showed other bed were marked with vertical lines. Review of the Siderail or Bedrail Assessment Guidance to Reduce Entrapment form for January 2025 showed Resident 37's bed was inspected on 1/20/25. The form showed Zones 1, 2, 3, 4, and 7, and frame were marked ok and Zones 5 and 6 were marked N/A for Resident 37's bed. Further review of the form showed other beds were marked with vertical lines. (continued on next page)

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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ESD verified the above findings. The ESD stated the entrapment assessment was conducted when the resident was not in the bed. The ESD stated they only marked ok when the bed passed the inspection, and n/a or not applicable. The ESD verified Zone 2 should have been checked. When asked about the other beds that were marked with vertical lines, the ESD stated those were the beds without grab bars, but the ESD was not able to explain why those rooms were marked with vertical lines. The ESD was not able to show a documented evidence of the regular inspection conducted for the beds without grab bars. 50967 4. Medical record review for Resident 5 was initiated on 1/22/25. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's H&P examination dated 2/3/24, showed Resident 5 had no capacity to understand and make decisions. Review of Resident 5's MDS dated [DATE], showed Resident 5s BIMS score was not conducted due to the resident rarely or never understood. Review of Resident 5's Order Summary Report dated 12/31/24, showed to use bilateral half side rails on both sides of the bed due to poor trunk control secondary to brain injury or seizures. On 1/22/24 at hours, a concurrent observation and interview was conducted with CNA 1. CNA 1 verified Resident 5 had the bilateral side rails elevated while in bed. CNA 1 stated Resident 5 required total assistance from staff with ADL cares. On 1/24/25 at 1225 hours, a concurrent interview and record review was conducted with the ESD. Review of the Side rail or Bed Rail Assessment Guidance to Reduce Entrapment Logs of Resident 5 dated 12/8/24, did not show Zone 2 entrapment assessment was completed. The ESD verified the finding. The ESD stated Zone 2 was not measured because it was close to the bed. On 1/27/24 at 0856 hours, a concurrent observation and interview was conducted with LVN 3. LVN 3 verified Resident 5 had bilateral half side rails elevated while resident in bed. On 1/27/25 1400 at hours, an interview was conducted with the DON and Administrator. The DON and Administrator were informed and acknowledged the above findings.