STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555535	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Valley Care Center	9000 Larkin Road Live Oak, CA 95953

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 49044 Based on interview, record review, and facility policy review, the facility failed to ensure they accurately coded the Minimum Data Set (MDS) for 4 (Residents #49, #81, #59 and #58) of 6 residents reviewed for MDS accuracy. Findings included: A facility policy titled, Resident Assessments revised in October 2023, revealed A comprehensive assessment of each resident is completed at intervals designated by OBRA regulations and PPS requirements from the Minimum Data Set (MDS) is submitted to the Internet Quality Improvement Evaluation System (iQIES) as required. The policy revealed, 9. Members of the care team participate in the resident assessment process. 10. Assessments are completed by staff members who are knowledgeable about the resident's needs. 11. Persons who have competed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information. 1. An Admission Record indicated the facility admitted Resident #49 on 02/18/2021. According to the Admission Record, the resident had a medical history that included diagnoses of unspecified dementia with mild agitation, major depressive disorder, and anxiety disorder. An annual MDS, with an Assessment Reference Date (ARD) of 07/05/2024, revealed a Staff Assessment for Mental Status (SAMS) determined Resident #49 had short- and long-term memory problems and had severely impaired cognitive skills for daily decision making. The MDS revealed the resident experienced inattention and disorganized thinking continuously. The MDS revealed the resident had no behaviors such as rejecting care or wandering during the seven-day lookback period. The MDS revealed the resident was able to ambulate with setup to supervision assistance and did not utilize a wheelchair. The MDS revealed the Social Services Assistant (SSA) signed as having completed Sections E (Behavior) of the MDS on 07/08/2024. Resident #49's care plan included a focus area initiated on 11/10/2022 and revised on 01/27/2023 that indicated the resident had episodes of being resistive to care related to dementia and at times they declined medications, showers, oral care, changing clothing, brief changing, toileting, and activities of daily living (ADL) care. The focus area revealed the resident could be difficult to redirect, had pacing behaviors, and could yell out at others. The focus area revealed the resident went into other residents' rooms and took property that was not theirs and could be difficult to redirect. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 06. Nursing - Elopement and Wandering Risk Observation/Assessment - V1.0 with an effective date of 07/03/2024 revealed staff indicated the resident ambulated independently with or without the use of an assistive device. The assessment revealed the resident wandered aimlessly or displayed wandering behaviors without a sense of purpose. The assessment revealed the resident had verbalized a desire to leave the facility, packed their belongings, stood by exit doors or attempted to open an exit door, but did not exhibit unsafe wandering or elopement attempts. A Behavior Symptoms (Advanced Reporting) task document revealed that within the MDS's seven-day lookback period, staff documented wandering behaviors for the resident on 06/29/2024, 06/30/2024, 07/01/2024 on two different occasions, 07/02/2024, and 07/04/2024. The document revealed staff also documented the resident exhibited behaviors including repetitive movements, yelling/screaming, kicking/hitting, grabbing, pinching/scratching/spitting, and rejection of care between 06/26/2024 and 07/05/2024. A Documentation Survey Report for July 2024 revealed staff documented the resident's behaviors symptoms of wandering on 07/01/2024 and 07/02/2024, and rejection of care on 07/01/2024, 07/03/2024, and 07/04/2024, all within the MDS's seven-day lookback period. During an interview on 07/10/2024 at 2:56 PM, Certified Nursing Assistant (CNA) #5 stated they had several residents, including Resident #49, who wandered in and out of other resident rooms. During an interview on 07/11/2024 at 1:30 PM, Licensed Vocational Nurse (LVN) #6 stated Resident #49 wandered and liked to go in and out of other residents' rooms. LVN #6 stated the resident would mess with sheets on the beds and move things around. LVN #6 stated Resident #49 was very quiet so they could not hear them. She stated Resident #49 required a lot of redirection. During an interview on 07/11/2024 at 1:59 PM, CNA #7 stated they had quite a few residents who wandered, including Resident #49, who wandered every day but not as much as they used to. During an interview on 07/11/2024 at 2:37 PM, the SSA stated she was assigned to provide social services on the long-term care unit. She stated she completed Section E (Behavior) of the MDS. She stated it was important for the MDS to be accurate to ensure they could track what was happening with the residents. The SSA stated to find the information she used to code her sections of the MDS she reviewed progress notes, physicians' orders, admissions records, and the electronic medication administration record (EMAR) from the last quarter. She stated she would use whatever information was documented in the progress notes. She stated she would go and talk to the staff on the floor to fill out the sections. She stated for behaviors to be documented in the seven-day lookback period on the MDS there would have to be some kind of documentation in the record for her to code it. She stated that if it was not documented, it did not happen, so she would not code it as wandering if she only had staff statements. She stated that she did not refer to the elopement assessment when she was coding wandering. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/11/2024 at 2:50 PM, the Social Service Director (SSD) stated social services coded Section E (Behavior). The SSD stated the MDS was a reflection of the resident and gave staff their aspect on what was going on. The SSD stated they completed Section E (Behavior) the day after the ARD date and were only allowed to code based on the documentation for that section. She stated they looked at behavior monitoring and the CNA documentation from the Point of Care (POC). She stated they did not look at the elopement risk assessments and did not believe they had looked at assessments for documentation and coding. The SSD stated they only talked to the CNAs if they needed to. She stated if for some reason the documentation was not there then they would talk to the staff. She stated she did not look into Resident #49. During an interview on 07/11/2024 at 4:40 PM, the Director of Nursing stated there were a few reasons why it was important for the MDS to be coded accurately. She stated it was an organized way to document how that resident was changing over time. She stated as she checked on the residents, she could look back to see the changes, as it was a composite of the resident's care. The DON stated the accuracy of all medical records was important. She stated information could be obtained from the staff, residents, and family as well as the medical records. The DON stated a wandering resident should be coded on the MDS. She stated she expected behaviors to be coded on the MDS. The DON stated behavior monitoring should be filled out and accurate. She stated as the registered nurse signing the MDS, she expected the staff who were putting in the information to be sure the MDS was complete and accurate. 2. An Admission Record indicated the facility admitted Resident #81 on 06/22/2023. According to the Admission Record, the resident had a medical history that included diagnoses of unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A quarterly MDS, with an Assessment Reference Date (ARD) of 05/17/2024, revealed Resident #81 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. The MDS revealed the resident exhibited physical behavioral symptoms directed towards others daily. The MDS revealed the resident did not reject care and did not experience any wandering. The MDS revealed the resident ambulated using a walker and ambulated with supervision or touching assistance. The MDS revealed the Social Services Assistant (SSA) signed to indicate her sections of the MDS had been completed on 05/20/2024 which included the section for behaviors. A 06. Nursing-Elopement Risk Observation/Assessment - V3.1 completed on 05/17/2024 indicated that Resident #81 was fully ambulatory, wandered aimlessly, and voiced a desire to leave. Resident #81's care plan did not address the resident's unsafe wandering in and out of other resident rooms. A Documentation Survey Report for May 2024 revealed that staff documented Resident #81 wandered on 05/12/2024, 05/14/2024, 05/15/2024, and 05/17/2024, all within the MDS's seven-day lookback period. During an interview on 07/10/2024 at 2:29 PM, Certified Nursing Assistant (CNA) #5 had to stop the interview because Resident #81 was in another resident's room, and she had to go attend to the resident. During a follow-up interview on 07/10/2024 at 2:56 PM, CNA #5 stated they had several residents that wandered, Resident #81 was one who wandered in and out of other resident rooms. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/11/2024 at 1:30 PM, Licensed Vocational Nurse (LVN) #6 stated Resident #81 wandered and liked to go in and out of other residents' rooms. She stated the resident liked to go in and look out the windows but did not take things from the other residents' rooms. During an interview on 07/11/2024 at 1:59 PM, CNA #7 stated they had quite a few residents who wandered, including Resident #81. She stated Resident #81 was one of the most unsafe with their wandering, going into other resident rooms frequently. During an interview on 07/11/2024 at 2:37 PM, the SSA stated she was assigned to provide social services on the long-term care unit. She stated she completed Section E (Behavior) of the MDS. She stated it was important for the MDS to be accurate to ensure they could track what was happening with the residents. The SSA stated to find the information she used to code her sections of the MDS she reviewed progress notes, physicians' orders, admissions records, and the electronic medication administration record (EMAR) from the last quarter. She stated she would use whatever information was documented in the progress notes. She stated she would go and talk to the staff on the floor to fill out the sections. She stated for behaviors to be documented in the seven-day lookback period on the MDS there would have to be some kind of documentation in the record for her to code it. She stated that if it was not documented, it did not happen, so she would not code it as wandering if she only had staff statements. She stated that she did not refer to the elopement assessment when she was coding wandering. She did not know what types of behaviors Resident #81 had and had not seen any behaviors during the lookback periods. During an interview on 07/11/2024 at 2:50 PM, the Social Service Director (SSD) stated social services coded Section E (Behavior). The SSD stated the MDS was a reflection of the resident and gave staff their aspect on what was going on. The SSD stated they completed Section E (Behavior) the day after the ARD date and were only allowed to code based on the documentation for that section. She stated they looked at behavior monitoring and the CNA documentation from the Point of Care (POC). She stated they did not look at the elopement risk assessments and did not believe they had looked at assessments for documentation and coding. The SSD stated they only talked to the CNAs if they needed to. She stated if for some reason the documentation was not there then they would talk to the staff. During an interview on 07/11/2024 at 4:40 PM, the Director of Nursing stated there were a few reasons why it was important for the MDS to be coded accurately. She stated it was an organized way to document how that resident was changing over time. She stated as she checked on the residents, she could look back to see the changes, as it was a composite of the resident's care. The DON stated the accuracy of all medical records was important. She stated information could be obtained from the staff, residents, and family as well as the medical records. The DON stated a wandering resident should be coded on the MDS. She stated she expected behaviors to be coded on the MDS. The DON stated behavior monitoring should be filled out and accurate. She stated as the registered nurse signing the MDS, she expected the staff who were putting in the information to be sure the MDS was complete and accurate. 3. An Admission Record indicated the facility admitted Resident #59 on 04/02/2024. According to the Admission Record, the resident had a medical history that included diagnoses of Alzheimer's disease with early onset, major depressive disorder, bipolar disorder, delirium due to known physiological condition, and personal history of traumatic brain injury. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A quarterly MDS with an Assessment Reference Date (ARD) of 07/05/2024 revealed Resident #59 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. The MDS revealed the resident had no physical, verbal, or other behavioral symptoms directed towards others during the seven-day lookback period. The MDS revealed the resident did not reject care during the seven-day lookback period. The MDS revealed the Social Services Assistant (SSA) signed on 07/08/2024 to indicate she had completed her sections of the MDS which included the section for behaviors. Resident #59's care plan included a focus area initiated 06/06/2024 that indicated the resident had exhibited behavioral symptoms. Interventions directed staff to maintain a calm, slow, understandable approach, observe whether the behavior endangers the resident and/or others, reduce stimulation, to frequently check on the resident, and for social services visits as indicated. A Documentation Survey Report for July 2024 revealed that staff documented Resident #59 exhibited yelling and screaming, wandering, pushing, rejection of care, and abusive language on 07/03/2024 and 07/05/2024, all within the MDS's seven-day lookback period. During an interview on 07/11/2024 at 2:37 PM, the SSA stated she was assigned to provide social services on the long-term care unit. She stated she completed Section E (Behavior) of the MDS. She stated it was important for the MDS to be accurate to ensure they could track what was happening with the residents. The SSA stated to find the information she used to code her sections of the MDS she reviewed progress notes, physicians' orders, admissions records, and the electronic medication administration record (EMAR) from the last quarter. She stated she would use whatever information was documented in the progress notes. She stated she would go and talk to the staff on the floor to fill out the sections. She stated for behaviors to be documented in the seven-day lookback period on the MDS there would have to be some kind of documentation in the record for her to code it. She stated that if it was not documented, it did not happen, so she would not code it as wandering if she only had staff statements. She stated that she did not refer to the elopement assessment when she was coding wandering. During an interview on 07/11/2024 at 2:50 PM, the Social Service Director (SSD) stated social services coded Section E (Behavior). The SSD stated the MDS was a reflection of the resident and gave staff their aspect on what was going on. The SSD stated they completed Section E (Behavior) the day after the ARD date and were only allowed to code based on the documentation for that section. She stated they looked at behavior monitoring and the CNA documentation from the Point of Care (POC). She stated they did not look at the elopement risk assessments and did not believe they had looked at assessments for documentation and coding. The SSD stated they only talked to the CNAs if they needed to. She stated if for some reason the documentation was not there then they would talk to the staff. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/11/2024 at 4:40 PM, the Director of Nursing stated there were a few reasons why it was important for the MDS to be coded accurately. She stated it was an organized way to document how that resident was changing over time. She stated as she checked on the residents, she could look back to see the changes, as it was a composite of the resident's care. The DON stated the accuracy of all medical records was important. She stated information could be obtained from the staff, residents, and family as well as the medical records. The DON stated a wandering resident should be coded on the MDS. She stated she expected behaviors to be coded on the MDS. The DON stated behavior monitoring should be filled out and accurate. She stated as the registered nurse signing the MDS, she expected the staff who were putting in the information to be sure the MDS was complete and accurate. 45555 4. An Admission Record indicated the facility admitted Resident #58 on 03/19/202. According to the Admission Record, the resident had a medical history that included diagnoses of moderate dementia with psychotic disturbance, recurrent major depressive disorder, anxiety disorder, disorientation, and unspecified intellectual disabilities. A quarterly MDS, with an Assessment Reference Date (ARD) of 05/31/2024, revealed Resident #58 had a Brief Interview for Mental Status (BIMS) score of 00, which indicated the resident had severe cognitive impairment. The MDS indicated the resident had physical behavioral symptoms directed toward others that occurred daily. The MDS did not indicate the resident wandered or rejected care. Resident #58's care plan included a focus area revised 08/30/2023 that indicated the resident was an elopement risk/wanderer, was ambulatory with a low BIMS score, and resided in the secure unit. Interventions directed staff to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversion, television, or books, monitor for fatigue and weight loss, and provide structured activities such as toileting, walking inside and outside, and reorientation strategies including signs, pictures, and memory boxes. Further review of Resident #58's care plan revealed it included a focus area revised 07/15/2023 that indicated the resident had episodes of being resistive to care, declining activities of daily living (ADL) care, vital signs, medications, weights, showers, toileting, meals, labs and could become verbally aggressive. The care plan indicated the resident had pacing behaviors, exit seeking behaviors, and would go into other resident's rooms accusing them of taking their belongings. Interventions directed staff to encourage as much participation/interaction by the resident as possible during care activities, give clear explanation of all care activities prior to and as they occur during each contact, maintain a calm environment, provide reassurance as needed, provide consistency in care to promote comfort with ADLs and maintain consistency in timing of ADLs, caregivers, and routine, as much as possible. A 0.6. Nursing-Elopement Risk/Observation/Assessment-V 3.1, dated 05/30/2024, revealed Resident #58 was at risk for elopement. The Observation/Assessment indicated the resident was fully ambulatory, wandered aimlessly and was unhappy with placement. The Observation/Assessment indicated the resident had no elopement attempts, had behaviors and was difficult to redirect. The Observation/Assessment indicated the resident had two or more psychotropic, mood-altering medications and had one neurological condition (dementia or any type of cognitive impairment) present. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 07/10/2024 at 9:44 AM revealed Resident #58 walking towards commotion occurring in the hallway and was going in and out of other residents' rooms as they walked. At 9:48 AM, Resident #58 entered Resident #86's and Resident #14's room and walked toward Resident #14's bed. Resident #14 pushed their wheeled walker towards Resident #58 and Resident #58 moved away from the bed and moved towards Resident #86's bed and laid down on the bed while Resident #86 pulled on the blanket under Resident #58, trying to get them out of the bed. During an interview on 07/11/2024 at 1:45 PM, the MDS Coordinator #18 stated MDS accuracy was important because the MDS represented the resident and was used for the coordination of resident care. She stated the information for the MDS came from chart review, including physician notes, assessments, physicians' assessments, and interviews with the resident. She stated the social services department did sections D & E (Mood and Behavior) of the assessment, but she would do it if they were not available. She stated in order to code a resident for wandering or behaviors, she would look at nurses and other progress notes and talk to the resident. During an interview on 07/11/2024 at 1:52 PM, /MDS Coordinator #13 stated if a resident were on the secure unit, she would not code the resident as wandering because that was what the unit was intended for, so that they could move about freely without worry of elopement. She stated she had not considered coding if a resident was wandering into other people's rooms. She stated the social service department did section D & E (Mood and Behavior) of the MDS. During an interview on 07/11/2024 at 2:37 PM, the Social Service Assistant (SSA) stated she was responsible for completing section E, when needed, of the MDS. She stated the accuracy of the MDS was important, so they knew the resident's status. She stated she got the information for the assessment from progress notes, physician orders, admission records, the medication and behavior administration records, and looked for any behaviors that the resident may have had in the progress notes. She stated she also spoke to the staff on the floor. She stated in order to code a behavior or wandering, it would have to have been documented in the seven-day lookback period. She stated if there was no documentation, then it did not occur, and they would not code it. The SSA stated they did not use the Elopement Risk/Observation/Assessment as part of their assessment. The SSA stated Resident #58 had a lot of behaviors and was sent to a Geri-psychiatric hospital previously for their behaviors. She stated the resident's wandering and combativeness should have been coded on the MDS. During an interview on 07/11/2024 at 2:50 PM, the Social Services Director (SSD) stated it was important for the MDS to be accurate because it was a reflection of the resident and what was going on with the resident. The SSD stated section E was completed the day after the ARD, and they were only able to code what was documented in progress notes, the MARs medication and behavioral monitoring, and documentation done by the certified nursing assistants (CNAs). She stated they did not look at past assessments and they did not look at the elopement assessment for documentation. She stated they would only ask the CNA if needed but mostly would go off the documentation. She stated she was not familiar with Resident #58 and could not comment on their MDS. During an interview on 07/11/2024 at 3:29 PM, the Administrator stated that MDS accuracy was important to get information to provide care and set up interventions. The Administrator stated his definition of wandering was walking aimlessly, trying to get out of the facility, or walking without purpose. He stated if it was documented that the resident was wandering then it should be included on the MDS. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/11/2024 at 4:40 PM, the Director of Nursing (DON) stated the MDS was an organized way to document the changes of a resident over time. She stated the information was a composite of resident care. She stated the information for the assessment came from interviews and record reviews. She stated if a resident was wandering or having behaviors it should be coded on the MDS if it was documented as occurring during the seven-day lookback period. The DON stated Resident #58 wandered and would go into other resident rooms and staff were to do frequent checks on them to ensure their whereabouts and safety.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 45555 Based on observation, interview, record review, and facility policy review, the facility failed to ensure they implemented the comprehensive person-centered care plan for 1 (Residents #58) of 23 residents reviewed for comprehensive person-centered care plans. Specifically, the facility failed to implement care plan interventions to prevent Resident #58 from wandering into other resident's rooms. Findings included: A facility policy titled, Care Plans, Comprehensive, last reviewed by the facility in October 2023, revealed, A comprehensive care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. An Admission Record indicated the facility admitted Resident #58 on 03/19/2021. According to the Admission Record, the resident had a medical history that included diagnoses of moderate dementia with psychotic disturbance, recurrent major depressive disorder, anxiety disorder, disorientation, and unspecified intellectual disabilities. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/31/2024, revealed Resident #58 had a Brief Interview for Mental Status (BIMS) score of 00, which indicated the resident had severe cognitive impairment. The MDS indicated the resident had physical behavioral symptoms directed toward others that occurred daily. Resident #58's care plan included a focus area revised 08/30/2023 that indicated the resident was an elopement risk/wanderer, was ambulatory with a low BIMS score and resided in the secure unit. Interventions directed staff to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversion, television, or books, monitor for fatigue and weight loss, and provide structured activities such as toileting, walking inside and outside, and reorientation strategies including signs, pictures, and memory boxes. An observation on 07/10/2024 at 9:44 AM revealed Resident #58 walking towards commotion occurring in the hallway and was going in and out of other resident's rooms as they walked. At 9:48 AM, Resident #58 entered Resident #86's and Resident #14's room and walked toward Resident #14's bed. Resident #14 pushed their wheeled walker towards Resident #58 and Resident #58 moved away from the bed and moved towards Resident #86's bed and laid down on the bed while Resident #86 pulled on the blanket under Resident #58, trying to get them out of the bed. During an interview on 07/11/2024 at 4:40 PM, the Director of Nursing (DON) stated the MDS should drive the care plan as well as patient care. She stated Resident #58 did walk from place to place and go into other residents' rooms and had some aggressive behaviors and she believed that the staff did check on the resident frequently. She stated it was very difficult to get the residents involved in some kid of sit-down activity, but they did try to get them involved in some kind of activity.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Valley Care Center	9000 Larkin Road Live Oak, CA 95953

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. 46659 Based on interview, record review, and facility policy review, the facility failed to provide medically-related social services by failing to identify the need for a guardian for 1 (Resident #47) of 23 sampled residents. Findings included: A facility policy titled, Social Services, revised 10/2010, indicated, Our facility provides medically-related social services to assure that each resident can attain or maintain his/her highest practicable physical, mental or psychosocial well-being. The policy revealed, 4. The social services department is responsible for: f. Making referrals to social service agencies as necessary or appropriate. and k. Working with individuals and groups in developing supportive services for residents according to their individual needs and interests. A facility document titled, Job Description Social Services Director, prepared 03/2017, indicated, Provide medically related social services so that the highest practicable physical, mental and psychosocial well-being of each resident is attained or maintained. The job description revealed, Assist residents with health care decision. Further review revealed, Assist in obtaining resources from community and social services agencies as well as health and welfare agencies to meet the needs of the resident. An Admission Record revealed the facility admitted Resident #47 on 10/31/2023. According to the Admission Record, the resident had a medical history that included diagnoses of hemiplegia and hemiparesis following a cerebral infarction, aphasia following a cerebral infarction, adult failure to thrive, dysarthria, and anarthria. The Admission Record revealed the resident was their own responsible party. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/03/2024, revealed Resident #47 had a Brief Interview for Mental Status (BIMS) score of 1, which indicated the resident had severe cognitive impairment. The MDS revealed the resident required substantial/maximal assistance for toileting and showers and required partial/moderate assistance for personal hygiene, putting on/taking off footwear and lower and upper body dressing, and was frequently incontinent of urine and bowel. Resident #47's care plan included a focus area initiated 04/18/2024, that indicated the resident had a psychosocial well-being problem. The focus area revealed the resident had a diagnosis of expressive aphasia. Interventions directed staff to encourage participation from the resident who depended on others to make own decisions, and to monitor and document the resident's usual response to problems. A Order Summary Report with active orders as of 07/11/2024 revealed an order dated 10/31/2023 for Resident does have the capacity to make his/her decisions related to: Hemiplegia and Hemiparesis. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/11/2024 at 12:16 PM, the Social Services Assistant (SSA) stated that the resident was their own responsible party, but she should have reached out to outside resources to get Resident #47 a guardian. During an interview on 07/11/2024 at 12:26 PM, the Social Services Director (SSD) stated that for Resident #47 they should have requested an order to change the resident's capacity since the residents BIMS assessment on admission revealed the resident had moderate cognitive impairment and the last two BIMS assessments revealed the resident had severe cognitive impairment. The SSD stated that when the provider changed a resident's capacity the Administrator, medical records staff, and social services would meet, and they would discuss the resident with the public guardians. The SSD stated that in her opinion Resident #47 should have had a guardian upon admission. She stated the facility failed to get the resident a guardian. During an interview on 07/11/2024 at 2:19 PM, the Director of Nursing (DON) stated she expected staff to provide social services to all residents to ensure they get the services needed. During an interview on 07/11/2024 at 2:43 PM, the Administrator stated he expected the staff to provide social services to the residents.

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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. 45555 Based on interview, record review, and facility policy review, the facility failed to have behavior monitoring for the use of an antianxiety medication, document non-pharmacological interventions prior to the use of an antianxiety medication, and have a specific duration for the use of an as-needed (PRN; pro re nata) antianxiety medication for 1 (Resident #27) of 5 residents reviewed for unnecessary medications. Findings included: A facility policy titled, Psychotropic Medication Use, revised 10/2023, specified, Psychotropic medications will be prescribed by the physician/nurse practitioner as warranted with the goal of providing quality of life. The policy also indicated, 6. The need to continue PRN orders for psychotropic medications requires that the practitioner document the rationale for the extended order. 7. The staff will observe, document, and report to the Physician/Nurse Practitioner information regarding the effectiveness of any interventions, including psychotropic medications. The policy also indicated, 8. Nursing staff shall monitor for and report any side effects and adverse consequences of psychotropic medications to the Attending Physician/Nurse Practitioner. An Admission Record indicated the facility admitted Resident #27 on 03/03/2022. According to the Admission Record, the resident had a medical history that included diagnoses of schizoid personality disorder and anxiety disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/21/2024, revealed a Staff Assessment for Mental Status (SAMS) determined Resident #27 had short- and long-term memory problems and had severe impairment in cognitive skills for daily decision-making. The MDS indicated that during the assessments seven-day lookback period the resident had physical behavioral symptoms directed toward others that occurred four to six days, but less than daily verbal behavioral symptoms directed toward others that occurred daily, and rejection of care that occurred one to three days. The MDS did not indicate the use of antianxiety medications during the assessment period. Resident #27's care plan did not include behaviors or use of an antianxiety medication. Resident #27's physician orders revealed an order for diazepam 2 milligrams (mg) with instructions to give one tablet by mouth every 24 hours as needed for anxiety with instructions to give every morning shift, ordered 07/05/2024. Further review revealed there was no stop date on the order or indication for length of duration. The orders did not include what behaviors to monitor for, what non-pharmacological interventions to try prior to administering the diazepam, or orders to monitor for side effects or effectiveness of the diazepam. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #27's Medication Administration Record [MAR] for the timeframe from 07/01/2024 through 07/09/2024 revealed the resident received diazepam 2 mg every morning for the timeframe from 07/06/2024 through 07/09/2024. There was no documentation of behavior monitoring, non-pharmacological interventions prior to the use of the diazepam, and no monitoring for side effects from the use of the diazepam. Resident #27's Treatment Administration Record [TAR] for the timeframe from 07/01/2024 through 07/09/2024 revealed no documentation of behavior monitoring, non-pharmacological interventions prior to the use of the diazepam, and no monitoring for side effects from the use of the diazepam. Resident #27's Progress Notes dated 07/05/2024 revealed verbal orders were received from the physician for diazepam 2 mg as needed every morning shift for anxiety. The note indicated the orders were carried out and the responsible party gave consent. Further review of Resident #27's Progress Notes for the timeframe from 07/05/2024 through 07/10/2024 revealed the resident was placed on Alert Charting for the use of diazepam. However, there were no notes indicating what behaviors the resident was having when the diazepam was administered or what non-pharmacological interventions were attempted other that being redirected on occasion. During an interview on 07/10/2024 at 2:41 PM, Licensed Vocational Nurse (LVN) #14 stated she would discontinue a PRN psychotropic medication if it was not being used. She stated she was not aware that there needed to be a stop date for psychotropic medications. LVN #14 stated the behaviors they were monitoring for Resident #27 included yelling, screaming, combativeness, and resistance to care. She stated they would try to redirect the resident and sometimes it would work and other times it would not. She stated they would also offer the resident food or a drink. She stated the non-pharmacological interventions should be documented on the MAR or TAR. During an interview on 07/10/2024 at 2:53 PM, LVN #15 stated they would trial psychotropic medications for 14 days to see if the medication was effective and then let the physician know to continue the order or change it to something else. She stated they should all have a 14-day stop date. She stated Resident #27 was taking diazepam continually about three months prior due to repetitive behavior and then it was discontinued when the behavior stopped. LVN #15 stated Resident #27 started having the same behaviors, so they started giving the resident Atarax in the morning, but it was not as effective, so they started the resident back on diazepam. She stated it was given in the morning when the resident was more agitated while they were trying to get the resident ready. She confirmed that there was not a stop date for the diazepam after checking the physician orders. She stated she assumed it was because the resident was on it previously and it was effective but stated since it was ordered PRN, it should have a stop date. During an interview on 07/11/2024 at 10:48 AM, the Medical Director, also Resident #27's Primary Care Provider (PCP) at the facility, stated she was in the facility and reviewed all residents at least monthly. She stated they did a team approach with the use of psychotropic medications. She stated she would usually order it for two weeks and then reassess the resident. She stated Resident #27's diazepam should have had a stop date. She stated she expected the staff to try other alternatives prior to giving a PRN medication and to monitor and document behaviors to be able to assess whether the medication was effective. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/11/2024 at 3:29 PM, the Administrator stated PRN psychotropic medications should have a 14-day stop date. He stated non-pharmacological interventions should be tried but were not always documented. He stated it should be documented that non-pharmacological interventions were attempted and not effective when the PRN medication was given. During an interview on 07/11/2024 at 3:51 PM, the Director of Nursing (DON) stated that when the nurse received an order for a PRN psychotropic medication, they should get consent from the family, add the order into the system, and include behavior monitoring and monitoring of side effects. She stated the resident would then be put on charting for 14 days for any changes. She stated then the resident would need to be reassessed after two weeks if it was a new order, or if they were on hospice, it may be longer. She stated residents on anti-anxiety medication might have an order for a longer period of time or they would get an order to give routinely since they could not predict the time of day they may need it. She stated they did need to have a stop date for psychotropic medications; generally, it was for two weeks. The DON stated other times the physician may write it for a longer period of time. She stated non-pharmacological interventions were tried but not always documented since they were offered as a nursing measure. During a follow-up interview on 07/11/2024 at 4:40 PM, the DON stated Resident #27 had uncontrollable yelling out, even after their needs were met. She stated she just put in an order to document the behaviors and side effects for the use of the diazepam. She stated it should have been put in when the order was renewed. She stated she would also need to put an order in for non-pharmacological interventions.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 45555 Based on observation, interview, record review, and facility policy review, the facility failed to have a medication error rate less than 5 percent (%) with a medication error rate of 13.79%. The facility had four medication errors out of 29 opportunities affecting 2 (Resident #10 and Resident #33) of 4 residents reviewed during the medication administration task. Findings included: A facility policy titled, Administering Medications, revised 10/2023, specified, Medications are administered in a safe and timely manner, and as prescribed The policy indicated, 2. Medications are administered in accordance with prescribed orders, including any required time frame. The policy revealed, 4. Medications are administered within one (1) hour before and (1) hour after the prescribed time, unless otherwise specified (for example, before and after meal orders). The policy indicated, 7. The individual administering the medication checks the label to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. An Admission Record revealed the facility admitted Resident #10 on 02/13/2013. According to the Admission Record, the resident had a medical history that included diagnosis of protein-calorie malnutrition, bradycardia, adult failure to thrive, iron deficiency anemia, and a personal history of other venous thrombosis and embolism. Resident #10's Order Summary Report with active orders as of 07/11/2024, revealed an order with a start date of 05/10/2024 for chewable aspirin 81 milligrams (mg) with instructions to give one tablet by mouth one time a day for cardiac health. The Order Summary Report revealed an order with a start date of 09/14/2022 for a multivitamin with minerals with instructions to give one tablet by mouth in the morning as a supplement. Observations on 07/10/2024 at 8:24 AM, revealed Registered Nurse (RN) #11 preparing and administering medication to Resident #10. RN #11 administered enteric coated aspirin instead of chewable aspirin and administered a multivitamin tablet that did not include minerals. During an interview on 07/10/2024 at 2:26 PM, RN #11 confirmed that she gave a multivitamin tablet without minerals. She stated she realized it afterwards and went to the medication room and got a bottle of multivitamins with minerals. She stated she missed that the resident was supposed to be getting chewable aspirin instead of the enteric coated. She stated she was going to call the physician to change it since the resident swallowed the pill and did not chew it. She stated she should have double checked the label of the medication with the orders and medication administration record (MAR) to ensure she was following the physician order. An Admission Record revealed the facility admitted Resident #33 on 02/04/2021. According to the Admission Record, the resident had a medical history that included a diagnosis of idiopathic peripheral autonomic neuropathy. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #33's Order Summary Report with active orders as of 07/11/2024, revealed an order with a start date of 03/16/2024 for Linzess (medication used for chronic constipation) oral capsule with instructions to give 145 micrograms (mcg) by mouth one time a day with specific instruction to give on an empty stomach at least 30 minutes prior to the first meal of the day for constipation. The Order Summary Report revealed an order with a start date of 03/16/2024 for topiramate (seizure medication) 50 mg with instructions to give 25 mg by mouth one time day for nerve pain. Resident #33's MAR for July 2024 revealed the Linzess was scheduled to be administered at 7:30 AM and topiramate was scheduled to be administered at 8:00 AM. Observations on 07/10/2024 at 9:01 AM, revealed MDS Coordinator #13, who was also a Licensed Vocational Nurse (LVN), preparing and administering medications to Resident #33. MDS Coordinator #13 administered the Linzess an hour and a half after it was scheduled to be administered and after the resident had already eaten breakfast. MDS Coordinator #13 also omitted administering topiramate 25 mg to Resident #33. During an interview on 07/10/2024 at 2:22 PM, MDS Coordinator #13 confirmed that Resident #33 had already eaten when she administered the Linzess and that it was administered late. She stated she checked the medication label with the order to ensure she was giving the right medications and was not sure how she missed giving the resident their topiramate. During an interview on 07/11/2024 at 3:29 PM, the Administrator stated the nurses should follow the instructions on the MAR to ensure medications were given properly and as ordered by the physician. During an interview on 07/11/2024 at 4:40 PM, the Director of Nursing (DON) stated that when the nurses were passing medications, they should follow the five rights: the right resident, right medication, right time, right route, and right dose. She stated medication should be given as ordered and if a medication was ordered before meals, it was either due to side effects or for the efficiency of the medication. She stated if a medication was due before a meal and the nurse did not get to it in a timely manner, the nurse should evaluate the order with the physician. She stated the nurse should have held the medication and notified the physician for an alternative if needed. She stated if a chewable aspirin were ordered, it would be because it could be crushed. She stated if a multivitamin with minerals was ordered, then they should be following the physician orders and giving the multivitamin with minerals. She stated when administering medications, the nurse should go through each order, click on the MAR when it was prepared, and then double check at the end to ensure all medications were given.

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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. 48417 Based on observation, interview, record review, and facility policy review, the facility failed to maintain an infection control program to prevent the transmission/development of infection for 1 (Resident #8) of 7 residents reviewed for infection control. Specifically, the facility failed to ensure that staff implemented enhanced barrier precautions (EBP) for Resident #8. Findings included: A facility policy titled, Multidrug-Resistant Organisms [MDRO]; Infection Precaution & Enhanced Standard Precautions, revised 03/2024, revealed, a. Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. An Admission Record revealed the facility admitted Resident #8 on 03/27/2024. According to the Admission Record, the resident had a medical history that included diagnoses of chronic respiratory failure with hypoxia and diabetes. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/28/2024, revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS revealed the resident required substantial to maximal assistance from staff with toileting hygiene. The MDS revealed the resident was frequently incontinent of bladder and bowel. Resident #8's Order Summary Report with active orders as of 07/09/2024 revealed an order dated 07/08/2024 for EBP related to klebsiella pneumoniae in their urine (03/27/2024). The order stated that a gown, gloves, and face shield as indicated, were required during high-contact resident care activities such as dressing, bathing/showering, transferring, hygiene, linen changes, brief changes, toileting assistance, device care, and wound care, every shift for standard barrier precautions. An observation on 07/09/2024 at 1:45 PM revealed Resident #8's room had enhanced standard precaution signage outside the door, and the call light was illuminated. Certified Nursing Assistant (CNA) #2 performed hand hygiene, knocked on the door and entered the room of Resident #8, and then shut the door. Upon entering the room, it was observed that CNA #2 was wearing gloves and holding a bed pan. CNA #2 stated he was performing incontinence care. A container of unused gowns was available inside the room. During an interview on 07/09/2024 at 1:54 PM, CNA #2 stated the enhanced standard precaution signage outside of Resident #8's room was related to a contagious disease, but he was not certain which disease the resident had. He stated he was supposed to put on a gown and wear a mask and gloves when entering any room with enhanced standard precaution signage. CNA #2 stated he did not notice the enhanced standard precaution signage when he approached the room. He stated he put a bed pan under Resident #8 and changed the resident's brief. He stated he received training on EBP in the past, and in-services were provided every Thursday; however, he usually had a busy transportation schedule on Thursdays and had not attended an in-service in about two months. He stated he only wore gloves when providing care to Resident #8, but he should have worn a gown and a mask. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/11/2024 at 12:00 PM, Licensed Vocational Nurse (LVN) #1, who is also the Infection Preventionist, stated that any residents with an MDRO, indwelling medical device, or wound required EBP. LVN #1 stated the personal protective equipment (PPE) was placed inside the room of residents on EBP. She stated multiple in-services for all staff were provided in April and May 2024 when the regulations changed, and any new hires received the information during orientation. She stated PPE should be used in those rooms when wound care, brief change, transfer, cleaning, or morning/evening care were provided. LVN #1 stated staff should determine what the resident needed and if it was close contact, then staff should perform hand hygiene and don PPE (gloves/gown). She stated she noticed that it was tiring for staff to wear the PPE due to so many residents on EBP. LVN #1 stated CNA #2 should have worn a gown, in addition to gloves, when caring for Resident #8 due to the bacteria in the resident's urine. During an interview on 07/11/2024 at 12:13 PM, the Director of Nursing (DON) stated EBP was for any residents with wounds, gastric-tubes, intravenous therapy, catheters, or an MDRO. The DON stated staff were expected to don a gown and wear gloves during close contact with a resident on EBP. The DON stated she expected CNA #2 to have worn a gown in addition to gloves when providing care to Resident #8. The Administrator was interviewed on 07/11/2024 at 12:22 PM. He stated that due to the increase of infections in healthcare settings, EBP was implemented to prevent the spread. The Administrator stated residents with a history of infections, wounds, catheters, or an MDRO required EBP. He stated if there was close contact with a resident on EBP, staff should be wearing a gown, gloves, and mask when providing care. The Administrator stated his expectation was for CNA #2 to wear a gown in addition to gloves when he provided care to Resident #8.