STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555536	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Regency Care Center	1770 W. LA Habra Blvd. LA Habra, CA 90631

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **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 provide the reasonable accommodations to meet the needs for one of 19 final sampled residents (Resident 540) and four nonsampled residents (Residents 9, 17, 81, and 740). * The facility failed to ensure the call lights were within reach and accessible for Residents 9, 17, and 740. * The facility failed to ensure the bed control was within reach and accessible for Resident 81. * Resident 540's call light button was observed not working. These failures had the potential to negatively impact the resident's psychosocial well-being or result in a delay to receive care. Findings: Review of the facility's P&P titled Call Lights Accessibility and Timely Response revised on 12/19/22, showed the following: -The purpose of this policy is to assure the facility is adequately equipped with a call light; -Staff will ensure the call light is within reach of resident and secured, as needed; -The call system will be accessible to residents while in their bed or other sleeping accommodations within resident's room. 1. On 10/07/24 at 0846 hours, an observation and concurrent interview was conducted with the DSD. Resident 9's call light was observed on the floor and not within reach of the resident. The DSD verified Resident 9's call light was on the floor. Medical record review for Resident 9 was initiated on 10/8/24. Resident 9 was readmitted to the facility on [DATE]. Review of Resident 9's H&P examination dated on 9/16/24, showed Resident 9 had no capacity to make medical decisions. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 10/7/24 at 0928 hours, an observation and concurrent interview was conducted with CNA 5. Resident 17's call light was observed on the floor mat and not within reach of the resident. CNA 5 verified Resident 17's call light was on the floor mat. Medical record review for Resident 9 was initiated on 10/8/24. Resident 17 was readmitted to the facility on [DATE]. Review of Resident 17's H&P examination dated on 12/14/23, showed Resident 17 had no capacity to make medical decisions. 3. On 10/7/24 at 0908 hours, an observation and concurrent interview was conducted with LVN 8. Resident 740's call light was observed clipped to the right side of Resident 740's wall, above the head of the bed and not within reach of the resident. LVN 8 verified Resident 740's call light was clipped to the right side of Resident 740's wall, above the head of the bed. Medical record review for Resident 740 was initiated on 10/8/24. Resident 740 was readmitted to the facility on [DATE]. Review of Resident 740's H&P examination dated on 1/21/24, showed Resident 740 had no capacity to make medical decisions. 4. On 10/7/24 at 0908 hours, an observation and concurrent interview was conducted with the DSD. Resident 81 was observed lying in bed and looking for her bed control. Resident stated, control para [NAME], which translated to bed control in English. Resident 81's bed control was observed on the floor. The DSD verified Resident 81's bed control was on the floor. Medical record review for Resident 81 was initiated on 10/8/24. Resident 81 was admitted to the facility on [DATE]. Review of Resident 81's MDS dated [DATE], showed Resident 81's BIMS score of 8 (meaning moderate cognitive impairment). On 10/8/24 at 1521 hours, an interview was conducted with the DON regarding Residents 9, 17, and 740's call lights and Resident 81's bed control. When the DON was asked the expectation for the residents' call light and bed control, the DON stated, Staff should place the call light and bed control within the residents' reach. If the resident is contracted or has paralysis, we would assess the resident and provide soft touch call light if appropriate and place it within reach. 47476 5. Review of the facility's P&P titled Call Lights: Accessibility and Timely Response revised 12/19/22, showed the call system must be acessisble to the residents while in their bed or other sleeping accomodations within the resident's room. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an initial tour of the facility on 10/7/24 at 0847 hours, an observation and concurrent interview was conducted with Resident 540 in his room. Resident 540 stated he used the call light button to call the staff if he needed help. Resident 540 stated his call light button did not work and proceeded to press the call light button. The SSD then walked into Resident 540's room and verified Resident 540's call light button was not working. The SSD stated the call light cord was out of the socket and not plugged in right; and proceeded to fix the call light cord. Resident 540 stated his call light was not working the night before for the whole night and every time he pressed it, it did not work. Medical record review for Resident 540 was initiated on 10/7/24. Resident 540 was admitted to the facility on [DATE]. Review of Resident 540's H&P examination dated 10/4/24, showed Resident 540 had the capacity to understand and make decisions. Review of Resident 540's MDS dated [DATE], showed Resident 540 required substantial/maximal assistance for bed mobility and transfers. On 10/10/24 at 0908 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43119 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the information on how to formulate an advance directive was provided to one of 19 final sampled residents (Resident 33). In addtion, the facility failed to ensure the POLST form was complete and copy of advance direction was obtained and maintained the medical record for two of 19 final sampled residents(Resident 23 and 87). These failures had the potential for the facility to provide treatment and services against the resident's wishes. Findings: 1. Review of the facility's P&P titled Residents' Rights Regarding Treatment and Advance Directives revised date 12/19/22, showed it is the policy of the facility to support and facilitate a resident's right to request, refuse, and/or discontinue medical or surgical treatment and to formulate an advance directive. On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident, if cognitively able to, would like to formulate an advance directive. Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff. Review of Resident 33's medical record was initiated on 10/7/24. Resident 33 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of the Physician's H&P examination dated 11/18/23, showed Resident 33 had the capacity to understand and make decisions. Review of the Quarterly MDS dated [DATE], showed Resident 33 had a BIMS of 14 (scores of 13-15 suggests intact cognition). Review of the Physician Orders for Life Sustaining Treatment (POLST) dated 3/30/22, showed under Section D for Information and Signatures, Resident 33 had no advance directive. However, review of the Advance Directive Acknowledgment form dated 12/7/20, showed Resident 33 had executed an advance directive. On 10/8/24 at 1113 hours, an interview was conducted with Resident 33. Resident 33 stated she did not have an advance directive and did not remember being provided with any information on how to formulate an advance directive. On 10/8/24 at 1523 hours, an interview with concurrent record review was conducted the SSA. The SSA acknowledged the Social Services assessment and notes did not show information on how to formulate an advance directive was provided to Resident 33. On 10/8/24 at 1544 hours, an interview with concurrent medical record review was conducted with the DON. The DON verified the findings and stated the POLST and Advance Directive Acknowledgement form had conflicting information. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/9/24 at 1417 hours, a follow up interview was conducted with the DON. The DON acknowledged the above findings and stated Resident 33 did not have an advance directive in the medical record and overflow. 48882 2. Medical record review for Resident 87 was initiated on 10/7/24. Resident 87 was admitted to the facility on [DATE]. Review of Resident 87's H&P examination dated 9/11/24, showed Resident 87 had the capacity to understand and make decisions. Review of Resident 87's the Physician Orders for Life-Sustaining Treatment (POLST) undated and signed by the physician showed Section D Information and Signatures was blank. Review of Resident 87's Advance Directive Acknowledgement dated 9/16/24, showed Resident 87 had executed an advance directive. Review of Resident 87's medical record failed to show a copy of Resident 87's advance directive. On 10/8/24 at 1428 hours, an interview and concurrent medical record review for Resident 87 was conducted with the SSD. The SSD stated on admission, the Admission Coordinator would inquire if the residents had an advance directive. If the resident had an advance directive, the Admissions Coordinator would request a copy of the advance directive. The SSD further stated if the Admissions Coordinator had requested a copy and a copy was not provided, the Admissions Coordinator would inform the Social Services Department to follow-up. When asked about the timeframe to follow-up to obtain a copy of the advance directive from the resident's family or RP, the SSD stated as soon as possible to ensure the resident's wishes were honored. The SSD was asked if Resident 87 had an advance directive. The SSD stated upon Resident 87's admission to the facility, Resident 87's RP stated they would fax his advance directive to the facility. When asked whether the facility had followed-up to obtain a copy of the advance directive, the SSD stated an advance directive was not uploaded in Resident 87's medical record. The SSD further stated she was unable to find the documentation to show the facility had followed-up to obtain a copy of Resident 87's advance directive. On 10/10/24 at 1056 hours, an interview and concurrent medical record review for Resident 87 was conducted with the DON. The DON verified the above findings. On 10/10/24 at 1556 hours, the Administrator, DON, and Medical Records Assistant were informed and acknowledged the above findings. 47476 3. Medical record review for Resident 23 was initiated on 10/7/24. Resident 23 was admitted to the facility on [DATE]. Review of Resident 23's Physician Orders for Life-Sustaining Treatment (POLST) dated 9/14/24, failed to show documented evidence as to whether Resident 23 had an advance directive or not. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 23's Advance Directive Acknowledgement form signed 9/29/24, showed Resident 23 had executed an advance directive and a POLST. Further review of Resident 23's medical record failed to show a copy of the advance directive was maintained in the resident's medical record. On 10/8/24 at 1428 hours, a concurrent interview and medical record review was conducted with the SSD. The SSD stated the admissions coordinator, upon the resident's admission, would assess if the resident had an advance directive. The SSD stated the resident was reassessed if they have an advance directive during admission and during their care plan meeting. The SSD verified Resident 23's POLST was incomplete and did not show the advance directive information. The SSD additionally verified there was no follow up regarding whether Resident 23 did or did not have an advance directive available. On 10/8/24 at 1535 hours, a concurrent interview and medical record review was conducted with RN 1. RN 1 verified Resident 23's AHCD (Advance Health Care Directive) was not maintained in Resident 23's medical record.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 37726 Based on observation and interview, the facility failed to maintain a clean and homelike environment for two of 19 final sampled residents (Residents 33 and 49) and two nonsampled residents (Residents 27 and 86). * Resident 86 was observed walking into resident Shower Room A to take a shower. Shower Room A was observed with a soiled towel on the bathroom floor and several unpackaged clean adult briefs lying on the floor and shower chair. * Resident 49 resided in Room C. Room C was observed with scratches and unpainted areas on the walls and bathroom door frame. The Room C curtains were observed with stains and discoloration. * Resident 27 resided in Room B. Room B was observed with scratches and unpainted areas on several areas of the walls. * Resident 33 resided in Room A. Room A was observed with scratches and chipped paint on several areas of the walls. These failures posed the risk for unsanitary conditions and had the potential to negatively impact the residents' quality of life. Findings: 1. On 10/9/24 at 0918 hours, an observation and concurrent interview was conducted with RN 2. Resident 86 was observed walking into resident Shower Room A to take a shower. Shower Room A was observed with a soiled towel on the bathroom floor and several unpackaged clean adult briefs lying on the floor and shower chair. RN 2 verified the findings and stated the soiled towel was an infection control concern. RN 2 stated the adult briefs should be kept in clean packaging for infection control. 2. On 10/9/24 at 0911 hours, an observation and concurrent interview was conducted with Resident 49. Resident 49 was observed lying in his bed in Room C. Room C was observed with scratches and unpainted areas on the walls and bathroom door frame. The Room C curtains were observed with stains and discoloration. Resident 49 stated he spent the majority of his time in his bed. Resident 49 stated he was unhappy with the condition of his room and his expectation was for his room to be kept clean and in good condition. 3. On 10/8/24 at 1105 hours, an observation and concurrent interview was conducted with Resident 27. Resident 27 was observed lying in her bed in Room B. Room B was observed with scratches and unpainted areas on several areas of the walls. Resident 27 stated it would make her room more livable if the walls were painted. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. On 10/8/24 at 1056 hours, an observation and concurrent interview was conducted with Resident 33. Resident 33 resided in Room A. Room A was observed with scratches and chipped paint on several areas of the walls. Resident 33 stated she was comfortable in her room; however, she felt her room needed to be maintained.

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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** 48882 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the Level 1 PASRR contained accurate information for two of 19 final sampled residents (Residents 53 and 77). * Resident 77 had a diagnosis of unspecified psychosis and major depressive disorder and was prescribed Seroquel (an antipsychotic); however the Level I PASRR showed Resident 77 had no diagnosed mental illness and was not prescribed psychotropic medications. * Resident 53 had a diagnosis of depressive disorder; however, the Level 1 PASRR screening showed Resident 53 had no diagnosed mental illness. These failures posed the risk for the residents' inappropriate placement in a long-term care nursing home when a PASRR Level II evaluation was not done. Findings: Review of the facility's P&P titled Resident Assessment-Coordination with PASRR Program revised 12/18/23, showed the facility coordinated assessments with the preadmission screening and resident review (PASRR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. Further review of the facility's P&P showed all applicants (residents) to the facility would be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. For the PASRR Level I screen, the initial pre-screening completed prior to admission: - a negative Level I screen would permit admission to proceed and ends the PASRR process unless a possible serous mental disorder or intellectual disability arises later. - a positive Level I screen necessitates a PASRR Level II evaluation prior to admission. 1. Medical record review for Resident 77 was initiated on 10/7/24. Resident 77 was admitted to the facility on [DATE], and readmitted on [DATE], with the diagnosis of unspecified psychosis and major depressive disorder. Review of Resident 77's H&P examination dated 9/20/24, showed Resident 77 had no capacity to understand and make decisions. Review of Resident 77's Preadmission Screening and Resident Review (PASRR) Level I Screening dated 9/18/24, showed Resident 77 had no diagnosis of serious mental illness and had not been prescribed psychotropic medications. The form showed the Level I screening was negative and a Level II evaluation was not required. (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 Resident 77's Order Summary Report dated 10/8/24, showed a physician's order dated 9/20/24, to administer Seroquel (antipsychotic) 25 mg one tablet by mouth at bedtime for psychosis manifested by unprovoked striking and yelling. On 10/9/24 at 0836 hours, an interview and concurrent medical record review for Resident 77 was conducted with the MDS Coordinator. The MDS Coordinator stated prior to admission to the facility, a PASRR screening would be conducted for the resident at the acute hospital. The results of the screening would be sent to the facility and reviewed by the MDS Coordinator for accuracy. The MDS Coordinator stated upon review of the PASRR Level I Screening, if the screening was inaccurate, she would amend the Level I Screening and determine if a Level II would be triggered or required for the resident. The MDS Coordinator stated the purpose of the PASRR screening was to determine supportive services for the residents with serious mental illnesses while residing at the nursing facility. The MDS Coordinator reviewed Resident 77's medical record and verified the above findings. The MDS Coordinator stated the Level I PASRR Screening was inaccurate, and Resident 77 could have potentially required a Level II PASRR evaluation, which was not conducted. On 10/10/24 at 1056 hours, an interview was conducted with the DON. The DON stated the licensed nurses were responsible for reviewing for accuracy of the PASRR Level I screening results. The DON further stated upon the review of the PASRR Level I Screening results, if the screening was inaccurate, she expected the licensed nurses to revise or conduct a new screening. On 10/10/24 at 1556 hours, the Administrator, DON, and Medical Records Assistant were informed and acknowledged the above findings. 37726 2. Medical record review for Resident 53 was initiated on 10/7/24. Resident 53 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 53's Level I PASRR screening dated 9/30/24, showed Resident 53 had no diagnosis of serious mental illness. The Level I PASRR screening showed the Level I screening was negative for suspected mental illness, therefore, a level 2 evaluation was not required. Review of Resident 53's H&P examination dated 8/30/24, showed Resident 53 had a diagnosis of depressive disorder. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/24 at 1156 hours, an interview and concurrent medical record review was conducted with the MDS Coordinator. The MDS Coordinator stated Resident 53 was readmitted to the facility from the acute care hospital on 9/29/24. The MDS Coordinator verified Resident 53's Level I PASRR screening dated 9/30/24, showed Resident 53 had no diagnosis of serious mental illness. The MDS Coordinator stated Resident 53's Level I PASRR screening was completed at the acute care hospital before Resident 53 was readmitted to the facility. The MDS Coordinator verified Resident 53's H&P examination dated 8/30/24, showed Resident 53 had a diagnosis of depressive disorder. The MDS Coordinator stated Resident 53 had a diagnosis of depressive disorder and required a PASRR resident review submission in order to inform the Department of Health Care Services of Resident 53's diagnosis of depressive disorder. The MDS Coordinator stated the purpose of informing the Department of Health Care Services of Resident 53's diagnosis was to ensure Resident 53 received a Level II mental health evaluation referral if necessary. The MDS Coordinator stated a Level II mental health evaluation was conducted to ensure the residents who resided in the long term care facilities would receive care and services specific to mental illness.

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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** 43119 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of 19 final sampled residents (Resident 62) was free from the accident hazards. * The facility failed to place the floor mattresses on both sides of Resdient 62's bed as ordered by the physician and resident's care plan for Resident 62. This failure had the potential for serious injury to the resident. Findings: Review of the facility's P&P titled Fall Prevention Program revised date 12/28/23, showed each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk. The nurse and/or interdisciplinary team will initiate interventions on the resident's care plan, in accordance with the resident's level of risk. On 10/7/24 at 1026 hours, during an initial tour, Resident 62 was observed lying in a low bed and no floor mattress was in place. On 10/8/24 at 1055 hours, Resident 62 was observed resting in a low bed with no floor mattress in place. Medical record review for Resident 62 was initiated on 10/7/24. Resident 62 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 62's Fall Risk assessment dated [DATE], showed Resident 62 was at risk for falling. Review of Resident 62's plan of care showed a care plan focus dated 7/13/22, and revised 5/5/23, addressing the risk for falls related to confusion, psychoactive drug use, psychosis, and dementia with behavioral disturbances. The interventions included low bed and application of floor mattresses to both sides of the bed. Review of Resident 62's Quarterly MDS dated [DATE], showed Resident 62 had severe cognitive impairment. Section GG showed Resident 62 had impairment to both lower extremities. Review of Resident 62's Order Summary Report dated 10/8/24, showed a physician's order dated 2/3/23, for fall risk precautions with low bed and floor mattresses to both sides of the bed. On 10/8/24 at 1510 hours, an interview with concurrent record review was conducted with LVN 6. LVN 6 stated she recalled Resident 62 had an order for the floor mats and verified a physician's order dated 2/3/23, for floor mattresses to both sides of the bed. LVN 6 acknowledged there was no floor mattress in place and stated it was an extra layer of protection. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/8/24 at 1537 hours, an observation with concurrent interview was conducted with the DON. The DON acknowledged there were no floor mattresses in place and stated the floor mattresses should have been used and the physician's order should have been followed.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to maintain the IV accesses for two of two residents (one final sampled resident, Resident 77 and one nonsampled resident, Resident 63) reviewed for IV care. * The facility failed to ensure the PICC line external catheter and arm circumference measurements were completed and documented in the residents' medical records for Residents 63 and 77 upon admission to the facility. In addition, the facility failed to obtain a physician's order for the care and maintenance of the PICC line for Resident 77, failed to develop a plan of care for the use of PICC, and failed to ensure the PICC dressings were changed weekly as per the facility's P&P for Residents 63 and 77. These failures had the potential to delay the identification of catheter related complications for Residents 63 and 77. Findings: Review of the facility's P&P titled PICC/Midline/CVAD Dressing Change revised 12/19/22, showed it is the policy of this facility to change peripherally inserted central catheter (PICC), midline, and central venous access device (CVAD) dressing, weekly or if soiled, in a manner to decrease potential for infection and/or cross contamination. Further review of the P&P showed the following: - to use sterile measuring tape to measure the external length of the catheter from the hub to the skin entry to ensure that it has not migrated, - to apply a transparent permeable dressing to the insertion site after cleaning the site with an antiseptic, - to label the dressing with the date, time, and initials, and - to document the procedure. Review of the facility's P&P titled Comprehensive Care Plans revised 12/19/22, showed the comprehensive care plan will describe at a minimum, the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 1. On 10/7/24 at 1238 hours, an observation was conducted of Resident 63. Resident 63 was observed to have a double lumen PICC line on the left upper arm with a transparent dressing dated 9/26/24. Medical record review for Resident 63 was initiated on 10/7/24. Resident 63 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 63's Order Summary Report dated 10/9/24, showed the following physician's orders: (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 9/20/24, to measure the external catheter length of the PICC line and arm circumference upon admission and every seven days during the day shift and as needed for site maintenance. - dated 9/20/24, to change the PICC lline transparent dressing per sterile technique upon admission and every seven days and as needed for site maintenance. Review of Resident 63's IV Administration Report for September 2024 showed Resident 63 was administered the following IV medications: - ceftriaxone (antibiotic medication) 2 gm intravenously one time a day for sepsis from 9/20/24 to 9/29/24 at 0900 hours, - micafungin (antifungal medication) 100 mg intravenously one time a day for fungal prophylaxis from 9/20/24 to 9/27/24 at 1700 hours. Further review of Resident 63's IV Administration Report for September 2024 failed to show documentation of the measurements for the external catheter length of the PICC line and arm circumference upon admission and failed to show documentation Resident 63's PICC line dressing was changed upon admission as per the physician's order. The IV Administration Report showed Resident 63's PICC line dressing was changed and the arm circumference and PICC line external catheter length were measured on 9/26/24. Review of Resident 63's IV Administration Report for October 2024 showed documentation Resident 63's PICC line dressing was changed and the external catheter length of Resident 63's PICC line and arm circumference were measured on 10/3/24. * Review of Resident 63's Clinical Admission assessment dated [DATE], showed documentation Resident 63 had a PICC line to the left upper arm. The insertion date was documented as 9/19/24, and the length of the PICC line was left blank. Further review of the admission assessment failed to show documentation the external catheter length of the PICC line and arm circumference were measured upon admission. * Review of Resident 63's medical record failed to show documentation the external catheter length of the PICC line and arm circumference were measured upon admission. *Review of Resident 63's plan of care failed to show a care plan problem addressing Resident 63's PICC line on the left upper arm. On 10/8/24 at 0920 hours, an observation and concurrent interview for Resident 63 was conducted with RN 1. RN 1 verified Resident 63's PICC line on the left upper arm. RN 1 stated she changed Resident 63's PICC line dressing this morning. The old PICC line dressing was observed in the trash can, dated 9/26/24. RN 1 verified this finding. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/8/24 at 0930 hours, an interview and concurrent medical record review for Resident 63 was conducted with RN 1. RN 1 stated for the residents admitted to the facility with a PICC line, the PICC line dressing would be changed the following day and weekly thereafter. RN 1 stated upon admission, the licensed nurses were responsible for measuring the arm circumference and external catheter length of the PICC line, extending from the insertion site to the port. RN 1 further stated the licensed nurse should document the measurements in the resident's medical record. RN 1 reviewed Resident 63's medical record and verified the above findings. RN 1 also verified she signed the IV Administration Report on 10/3/24, that she changed and measured the PICC line external catheter length and arm circumference for Resident 63. When asked about the date of 9/26/24, on the old PICC line dressing, RN 1 stated she worked on 10/3/24, and did not have time to change the PICC line dressing for Resident 63 and had endorsed the task. When asked about the facility practice for documentation, RN 1 stated the facility practice was to sign after the procedure had been rendered. RN 1 further stated she should not have signed in the IV Administration Report if she had not completed the task. 2. On 10/7/24 at 0923 hours, an observation was conducted of Resident 77. Resident 77 was observed in bed, with vancomycin (antibiotic) 750 mg infusing at 100 ml/hr to Resident 77's right upper arm PICC. Resident 77's PICC was observed with two lumens and a transparent dressing dated 9/24/24. Medical record review for Resident 77 was initiated on 10/7/24. Resident 77 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 77's H&P examination dated 9/20/24, showed Resident 77 had no capacity to understand and make decisions. Review of Resident 77's Order Summary Report dated 10/8/24 showed the following physician's orders: - dated 10/8/24, to measure the external catheter length of the PICC line and arm circumference upon admission and every seven days during the day shift and as needed for site maintenance. - dated 10/8/24, to change the PICC/midline transparent dressing per sterile technique upon admission and every seven days and as needed for site maintenance. Review of Resident 77's IV Administration Report for September and October 2024 showed Resident 77 was administered the following IV medications: - piperacillin-tazobactam (antibiotic) in dextrose intravenous solution 3-0.375 gm/50 ml at 12.5 ml/hr intravenously every eight hours for leukocytosis and pneumonia from 9/19/24 to 9/24/24 at 0600, 1400, and 2200 hours. - vancomycin hcl 1 gm intravenously one time daily for pneumonia on 9/19/24 at 0900 hours, - vancomycin hcl, 500 mg intravenously one time daily for pneumonia from 9/20/24 to 9/22/24 at 0900 hours, - vancomycin hcl 750 mg intravenously one time daily for pneumonia from 9/23/24 to 10/8/24 at 0900 hours. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* Further review of Resident 77's IV Administration Report for September 2024 failed to show documentation the length of the external catheter of the PICC line and arm circumference were obtained upon admission and seven days thereafter, and failed to show documentation Resident 77's PICC line dressing was changed upon admission and every seven days thereafter. * Review of Resident 77's N Adv - Skilled Evaluation- V17 dated 9/19/24, showed documentation Resident 77 had a PICC line on admission. However, the sections for IV location, insertion date, and length of the PICC line were left blank. Further review of the document failed to show documentation Resident 77's external catheter length of PICC line and arm circumference were measured upon admission. * Review of Resident 77's medical record failed to show documentation the external catheter length of the PICC line and arm circumference were measured upon admission. * Review of Resident 77's plan of care failed to show a care plan problem addressing Resident 77's PICC line on the right upper arm. On 10/8/24 at 0943 hours, an interview and concurrent medical record review for Resident 77 was conducted with RN 1. RN 1 stated Resident 77 was readmitted to the facility with a right upper arm PICC line. When asked about Resident 77's last PICC line dressing change, RN 1 stated she had changed Resident 77's PICC line dressing that morning. When asked when the last PICC line dressing was changed, RN 1 stated Resident 77 did not have an order to change the PICC line dressing since her admission to the facility. RN 1 verified the above findings. On 10/8/24 at 0953 hours, an interview and concurrent observation was conducted in Resident 77's room with RN 1. The old PICC line dressing was observed in Resident 77's trash can. The old PICC line dressing was observed labeled with the date of 9/24/24. RN 1 verified the findings and stated the PICC line dressing should be changed weekly. On 10/10/24 at 1056 hours, an interview and concurrent medical record review for Residents 63 and 77 was conducted with the DON. The DON stated for the residents admitted to the facility with a PICC line, the RN was responsible for obtaining measurements of the external catheter length of the PICC line and arm circumference and should document in the resident's medical record. The DON stated the PICC line dressing should be changed weekly and as needed, and each resident should have a care plan to address the PICC line. The DON reviewed the medical record for Residents 63 and 77 and verified the above findings. On 10/10/24 at 1556 hours, the Administrator, DON, and Medical Records Assistant were informed and acknowledged the above findings.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the appropriate pain management for one of one final sampled resident (Resident 87) reviewed for pain management. * The facility failed to administer pain medication according to the physician's order for Resident 87. This failure had the potential for ineffective pain management for Resident 87. Findings: Review of the facility's P&P titled Pain Management revised 12/19/22, showed in order to help the resident attain or maintain his/her highest practicable level of physical, mental, and psychosocial well-being and to prevent or manage pain, the facility will manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences. Review of the facility's P&P titled Medication Administration revised 12/19/22, showed the medications are administered by licensed nurses, or other staff who are legally authorized to do so, as ordered by the physician and in accordance with professional standards of practice. Medical record review for Resident 87 was initiated on 10/7/24. Resident 87 was admitted to the facility on [DATE]. Review of Resident 87's H&P examination dated 9/11/24, showed Resident 87 had the capacity to understand and make decisions. Review of Resident 87's Order Summary Report dated 10/9/24, showed the following physician's orders dated 9/26/24: - to administer oxycodone hcl (opioid, narcotic pain medication) 5 mg one tablet by mouth every four hours as needed for moderate pain (pain levels of 5-7, on a 0 to 10 pain scale, 0 = no pain and 10 = worst pain), - to administer oxycodone hcl 5 mg two tablets by mouth every four hours as needed for severe pain (pain levels of 8-10). Review of Resident 87's MAR for October 2024 showed Resident 87 was administered oxycodone hcl 5 mg one tablet by mouth every four hours as needed for moderate pain (pain levels of 5-7) for the following pain levels on the following dates and times: - on 10/2/24 at 1100 hours, a pain level of 8. - on 10/8/24 at 1100 hours, a pain level of 8; and at 1515 hours, a pain level of 8. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 87's plan of care showed a care plan problem dated 9/10/24, addressing Resident 87's risk for acute/chronic pain related to central cord syndrome C1 (the most common form of cervical spinal cord injury, characterized by loss of power and sensation in arms and hand), wedge compression fracture of the first lumbar vertebra (a type of vertebral compression fracture that occurs when the front of the vertebra collapses, giving it a wedge shape), multiple fractures of the left ribs, status post laminectomy with fusion (spine surgery used to reduce or entirely remove pressure being put on the lumbar area of the spinal cord or spinal nerves by making the spinal canal larger, and then adding spinal stability with fusion) and malignant neoplasm of the prostate. The interventions showed to administer analgesia medication as per the orders and to administer oxycodone hcl as ordered. On 10/9/24 at 1257 hours, an interview and concurrent medical record review for Resident 87 was conducted with LVN 7. LVN 7 verified the above findings and stated per Resident 87's pain level, Resident 87 should have been administered with oxycodone hcl 5 mg two tablets. When asked about the potential risk of administering pain medication outside of the ordered parameters, LVN 6 stated there may be the potential for insufficient pain relief for the resident. On 10/10/24 at 1056 hours, an interview was conducted with the DON. The DON stated for the administration of pain medications, the licensed nurses were expected to assess the resident's pain and administer the pain medication as ordered by the physician, for the indicated pain level reported by the resident. On 10/10/24 at 1556 hours, the Administrator, DON, and Medical Records Assistant were informed and acknowledged the above findings.

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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** 47476 Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to attain and maintain the highest physical well-being for one of one final sampled resident (Resident 23) reviewed for dialysis. * The facility failed to ensure the intake and output for Resident 23 were monitored and documented as ordered. This failure had the potential for Resident 23 having an excess of fluids, which could affect other vital organs in the body due to the resident's impaired kidney function. Findings: Review of the facility's P&P titled Fluid Restriction revised 12/2022 showed it is the policy of this facility to ensure that fluid restrictions will be followed in accordance to physician's orders. Medical record review for Resident 23 was initiated on 10/7/24. Resident 23 was admitted to the facility on [DATE], with diagnoses including end stage renal disease requiring dialysis three days a week. Review of Resident 23's Order Summary Report dated 10/7/24, showed a physician's order dated: - 9/19/24, for dialysis every Monday, Wednesday, and Friday at 0830 - 1230 hours. - 9/26/24, for fluid restriction of 1000 ml/ 24 hours: dietary, breakfast - 240 ml, lunch 120 ml, dinner - 120 ml nursing: 120 ml (11 - 7 hours shift), 200 ml (7 - 3 hours shift), and 200 ml (3 - 11 hours shift). The order showed 480 ml/day for dietary and 520 ml/day for nursing. Review of Resident 23's Monitor Record dated September and October 2024 showed the following documentation for Resident 23's ordered fluid restriction: - From 9/26 - 9/30/24: X was recorded in the areas marked for CC. - From 10/1 - 10/7/24: X was recorded in the areas marked for CC. On 10/8/24 at 1109 hours, a concurrent interview and medical record review was conducted with RN 1. RN 1 stated Resident 23 was on a fluid restriction and the facility gave the resident how much he needed to drink, and he was supposed to have the intakes and outputs recorded. RN 1 verified they were not documenting the fluid restriction and the documentation did not show how much Resident 23 was taking during the nurses' shifts. On 10/10/24 at 0859 hours, a concurrent interview and medical record review was conducted with the DON. The DON verified the above findings and verified there was no documented evidence from the nurses showing how much fluid Resident 23 had taken during their shift.

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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** 43119 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure four of 19 final sampled residents (Residents 53, 77, 80, and 83) and one nonsampled resident (Resident 24) remained free from the accident hazards due to the use of side rails. * The facility failed to ensure the Physician's Documentation of Informed Consent for Resident 83 was accurately completed, had missing physician's signature, and was undated. * The facility failed to ensure the physician's order was obtained and care plan was initiated for the use of side rails for Residents 77 and 80. * The facility failed to obtain the physician's order and initiate a care plan problem for the use of the bilateral half side rails for Residents 77 and 80. * The facility failed to ensure the Physician's Documentation of Informed Consent for Resident 83 was signed by the physician prior to Resident 83 using the bilateral side rails. * The facility failed to obtain informed consent prior to the use of elevated side rails for Resident 53. These failures had the potential risk for injury to the residents. Findings: The FDA issued a Safety Alert entitled Entrapment Hazards with Hospital Bed Side Rails. Residents most at risk for entrapment are those who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, acute urinary retention, etc. , that may cause them to move about the bed or try to exit from the bed. Entrapment may occur when a resident is caught between the mattress and bed rail or in the bed rail itself. Inappropriate positioning or other care related activities could contribute to the risk of entrapment. Review of the facility's P&P titled Informed Consent revised date 3/25/24, showed it is the policy of the facility to uphold the rights of residents to participate in the planning and decision-making process concerning their care and treatment. When situations arise that involve complex decisions, the facility will verify that informed consent has been obtained prior to any medical intervention or treatment is initiated, including, but not limited to, administration of psychotherapeutic medications, application of a physical restraint or the prolonged use of a device that may lead to the inability to regain use of a normal body function and for transfer and discharge. Until such time as devices are identified by statue or regulation that lead to the inability to regain use of a normal bodily function are defined, this portion of the policy will not be enacted. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Medical record review for Resident 83 was initiated on 10/7/24. Resident 83 was admitted to the facility on [DATE]. Review of the Physician's H&P examination dated 8/6/24, showed Resident 83 had a diagnosis of Alzheimer's disease and had no capacity to understand and make decisions. Review of Resident 83's Order Summary Report dated 10/8/24, showed a physician's order dated 8/3/24, for the bilateral half side rails as an enabler and for mobility. Review of Resident 83's plan of care showed a care plan focus dated 8/9/24, for the bilateral half side rails management. Risk for entrapment and impairment in skin discoloration related to enabler use to assist with mobility and transfer. The interventions included obtained informed consent. Review of Resident 83's Physician's Documentation of Informed Consent showed a missing physician's signature and was undated. On 10/7/24 at 1012 hours, during an initial tour, Resident 83's bed was observed with bilateral half side rails elevated at the head of the bed. Resident 83 was lying in bed, asleep with eyes closed. On 10/8/24 at 1501 hours, an observation with concurrent interview was conducted with LVN 5. LVN 5 acknowledged there was the bilateral half side rails in place and stated there should be an informed consent. On 10/9/24 at 1632 hours, an interview with concurrent record review was conducted with the DON. The DON acknowledged the informed consent had missing physician's signature and was undated. The DON stated it should have been signed by the provider. 48882 2. On 10/7/24 at 0923 hours, 10/8/24 at 1001 hours, and 10/9/24 at 0750 hours, Resident 77 was observed in bed with the bilateral half side rails elevated. Medical record review for Resident 77 was initiated on 10/7/24. Resident 77 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 77's H&P examination dated 9/20/24, showed Resident 77 had no capacity to understand and make decisions Review of Resident 77's Order Summary Report dated 10/8/24, failed to show the physician's order for Resident 77's bilateral half side rail use. Review of the facility's document titled Restrictive Measures- Risks/Benefits for Resident 77 dated 9/18/24, showed half bilateral side rails were indicated for bed mobility and transfer. Review of Resident 77's plan of care failed to show a care plan problem addressing Resident 77's bilateral half side rails use. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/8/24 at 1213 hours, an interview was conducted with CNA 9. CNA 9 stated Resident 77 used the side rails during incontinent care for assistance with the turning. On 10/9/24 at 1035 hours, an interview and concurrent medical record review for Resident 77 was conducted with LVN 7. LVN 7 stated Resident 77 used the side rails for repositioning and turning in bed. LVN 7 verified the above findings. On 10/10/24 at 1056 hours, an interview was conducted with the DON. The DON stated there should always be a physician's order for the use of side rails and a care plan problem should be initiated to address the residents use of the side rails. The DON was informed and acknowledged the above findings. 3. On 10/7/24 at 0941 hours and 10/8/24 at 0908 hours, Resident 80 was observed in bed with the bilateral half side rails elevated. Medical record review for Resident 80 was initiated on 10/7/24. Resident 80 was admitted to the facility on [DATE]. Review of Resident 80's H&P examination dated 7/1/24, showed Resident 80 had the capacity to understand and make decisions. Review of Resident 80's quarterly MDS dated [DATE], showed Resident 80 required substantial/maximal assistance for rolling from the lying position to the left and right. Review of Resident 80's Order Summary Report dated 10/9/24, failed to show the physician's order for Resident 80's bilateral half side rail use. Review of Resident 80's plan of care failed to show a care plan problem addressing Resident 80's bilateral half side rail use. On 10/7/24 at 0941 hours, an interview was conducted with Resident 80. Resident 80 stated she used the bed side rails to grab onto during care and for repositioning in bed. On 10/8/24 at 1220 hours, an interview was conducted with CNA 9. CNA 9 stated Resident 80 used the side rails during incontinent care for assistance with turning. On 10/10/24 at 1056 hours, an interview and concurrent medical record review for Resident 80 was conducted with the DON. The DON verified the above findings. The DON stated there should always be a physician's order for the use of side rails and a care plan problem should be initiated to address the residents' use of side rails. On 10/10/24 at 1556 hours, the Administrator, DON, and Medical Records Assistant were informed and acknowledged the above findings. 50787 (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. On 10/7/24 at 1000 hours, an observation and concurrent interview was conducted with Resident 24. Resident 24 was observed lying in bed holding both elevated side rails. Resident 24 stated he used the side rails to assist with turning, positioning and exercising. On 10/9/24, at 0800 hours, an observation and concurrent interview was conducted with CNA 7. CNA 7 verified Resident 24's use of bilateral side rails and stated the resident was using the rails to move around. Medical record review for Resident 24 was initiated on 10/9/24. Resident 24 was admitted to the facility on [DATE]. Review of Resident 24's MDS dated [DATE], showed Resident 24's BIMS score was 7 (meaning severe cognitive impairment). Review of Resident 24's Order Summary Report dated 9/30/24, showed a physician's order dated 9/23/23, for the use of bilateral half side rails for bed mobility and transfer. Review of Resident 24's Facility Verification of Informed Consent dated 9/27/23, showed the prolonged use of the bilateral half side rails for mobility and transfers. The form showed the verification of informed consent was obtained from the Resident's wife via phone with two staff signatures. Review of Resident 24's Physician Documentation of Informed Consent showed the prolonged use the bilateral half side rails for mobility and transfer. The Physician Documentation of Informed Consent did not show the signature of the physician as indicated but was dated 9/27/23. At 10/10/24 at 1518 hours, an interview was conducted with the Administrator and DON. The Administrator and DON acknowledged and verified the above finding. 37726 5. Medical record review for Resident 53 was initiated on 10/7/24. Resident 53 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of the physician's order dated 9/29/24, showed an order for the bilateral side rails for bed mobility and enabler use. Review of Resident 53's Bed Rails Re-admission assessment dated [DATE], showed Resident 53 had bed mobility issues due to cognitive loss and difficulty moving to a sitting position from the bed. Further review of the document showed the RN had left a voice message for Resident 53's representative (in an attempt to obtain informed consent for the use of side rails). On 10/7/24 at 1005 hours, an observation and concurrent interviw was conducted with Resident 53. Resident 53 was observed lying in bed with the bilateral side rails elevated at the head of the bed. Resident 53 stated he utilized the side rails for repositioning. On 10/10/24 at 0856 hours, an additional observation was conducted of Resident 53. Resident 53 was observed lying in bed with the bilateral side rails elevated at the head of the bed. (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 53's medical record failed to show documentation for an informed consent for the use of the side rails was obtained. On 10/10/24 at 0922 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified the facility failed to obtain an informed consent for Resident 53's elevated side rails (for Resident 53's re-admission to the facility on [DATE]).

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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 pharmaceutical services to ensure accurate reconciliation for the controlled medications for one of 19 final sampled residents (Resident 541) and three nonsampled residents (Residents 48, 741, and 742). * The facility failed to ensure the administration of the controlled medications for Residents 54, 741, and 742 were accurately reconciled and documented in the MAR. * The facility failed to ensure the administration of the controlled medication for Resident 48 was documented in the controlled drug record and MAR. * The facility failed to ensure the Controlled Substance Shift Count Log for Medication Cart C was completed every shift. These failures posed the risk for diversion of medications. Findings: Review of the facility's P&P titled, Medication Administration revised on [DATE], showed the following: - Keep medication cart clean, organized, and stocked with adequate supplies; - Identify expiration date. If expired, notify nurse manager; - Sign MAR after administered; - If medication is a controlled substance, sign narcotic book; - Correct any discrepancies and report to nurse manager. Review of the facility's P&P titled, Controlled Substance Administration and Accountability revised [DATE], showed the following: - Safeguards in place to prevent loss, diversion, or accidental exposure. - All controlled substance obtained from a non-automated medication cart or cabinet are recorded on the designated usage form. Written documentation must be clearly legible with all applicable information provided. - All specially compounded or non-stock Schedule II controlled substances dispensed from the pharmacy for a specific patient are recorded on the Controlled Drug Record supplied with the medication or other designated forms as per facility policy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- In all cases, the dose noted on the usage form or entered into the automated dispensing system must match the dose recorded on the Medication Administration Record (MAR), Controlled Drug Record, or other facility specified form and placed in the patient's medical record. - The Controlled Drug Record (or other specified form) serves the dual purpose of recording both narcotic disposition and patient information. - The Controlled Drug Record is a permanent medical record document and in conjunction with the MAR is the source for documenting any patient-specific narcotic dispensed from the pharmacy. 1.a. Medical record review for Resident 54 was initiated on [DATE]. Resident 54 was readmitted to the facility on [DATE]. Review of Resident 54's H&P examination dated [DATE], showed Resident 54 had no capacity to understand and make decisions. Review of Resident 54's Order Summary Report showed a physician's order dated [DATE], to administer hydrocodone/apap (a narcotic medication to treat pain) ,d+[DATE] mg one tablet by mouth every four hours as needed for severe pain. On [DATE] at 1458 hours, a controlled medication reconciliation for Residents 54 was conducted with LVN 7. Review of Resident 54's Antibiotic or Controlled Drug Record showed hydrocodone/apap ,d+[DATE] mg was signed out on [DATE] at 1200 hours. However, review of Resident 54's electronic MAR for [DATE] failed to show documented evidence hydrocodone/apap ,d+[DATE] mg was administered to Resident 54 on [DATE] at 1200 hours, as shown in the Antibiotic or Controlled drug Record. LVN 7 verified the above finding. b. Medical record review for Resident 741 was initiated on [DATE]. Resident 741 was admitted to the facility on [DATE]. Review of Resident 741's H&P examination dated [DATE], showed Resident 741 had the capacity to understand and make decisions. Review of Resident 741's Order Summary Report showed a physician's order dated [DATE], to administer hydrocodone/apap ,d+[DATE] mg one tablet by mouth every four hours as needed for moderate to severe pain. On [DATE] at 1458 hours, a controlled medication reconciliation for Residents 741 was conducted with LVN 7. Review of Resident 741's Antibiotic or Controlled Drug Record showed hydrocodone/apap ,d+[DATE] mg was signed out on [DATE] at 0900 hours, and [DATE] at 1000 hours. However, review of Resident 741's electronic MAR for [DATE] failed to show documented evidence hydrocodone/apap ,d+[DATE] mg was administered to Resident 741 on [DATE] at 0900 hours, and [DATE] at 1000 hours, as shown in the Antibiotic or Controlled drug Record. LVN 7 verified the above finding and stated she was supposed to sign the MAR after administering the hydrocodone/apap medication to Resident 741. c. Medical record review for Resident 742 was initiated on [DATE]. Resident 742 was admitted to the facility on [DATE]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 54's H&P examination dated [DATE], showed Resident 54 had the capacity to understand and make decisions. Review of Resident 742's Order Summary Report showed a physician's order dated [DATE], to administer zolpidem (Ambien) (a controlled medication to treat insomnia/difficulty sleeping) 5 mg by mouth every 24 hours as needed for insomnia. On [DATE] at 1458 hours, a controlled medication reconciliation for Residents 742 was conducted with LVN 7. Review of Resident 742's Antibiotic or Controlled Drug Record showed zolpidem 5 mg was signed out on [DATE] at 2100 hours. However, review of Resident 741's electronic MAR for [DATE] failed to show documented evidence zolpidem 5 mg was administered to Resident 742 on [DATE] at 2100 hours, as shown in the Antibiotic or Controlled drug Record. LVN 7 verified the above finding. On [DATE] at 1447 hours, an interview was conducted with RN 3. RN 3 verified he worked on [DATE], and was assigned to administer the medications to Resident 742 at 2100 hours. RN 3 stated he recalled administering the zolpidem medication to Resident 742 but did not document in the MAR after administering the medication. RN 3 stated he was supposed to document in the the MAR right after administering the medication. 2. Medical record review for Resident 48 was initiated on [DATE]. Resident 48 was readmitted to the facility on [DATE]. Review of Resident 48's H&P examination dated [DATE], showed Resident 48 had no capacity to understand and make decisions. Review of Resident 48's Order Summary Report showed a physician's order dated [DATE], to administer hydrocodone/apap ,d+[DATE] mg one tablet by mouth one time a day for pain management. On [DATE] at 1033 hours, a controlled medication reconciliation for Resident 48 was conducted with LVN 5. Review of Resident 48's MAR for [DATE] showed the hydrocodone/apap medication was administered on [DATE] at 0900 hours. Resident 48's medication bubble pack (a package used to dispense medications) for hydrocodone/apap showed two tablets remaining. However, review of Resident 48's Antibiotic or Controlled Drug Record showed three tablets remaining and there was no documented evidence to show the hydrocodone/apap medication was signed out on [DATE] at 0900 hours. LVN 5 verified the above finding. LVN 5 stated he forgot to sign off the hydrocodone medication after administering the morning dose. LVN 5 stated the protocol for administering medication was to pour pass, and sign. 3. On [DATE] at 1051 hours, a controlled medication reconciliation for Medication Cart C was conducted with LVN 5. Medication Cart C's Controlled Substance Shift Count Log was observed with two missing signatures from the licensed nurses for the following dates and shifts: - dated [DATE], off-going nurse for ,d+[DATE] shift (,d+[DATE] hours); and - dated [DATE], on-coming nurse for ,d+[DATE] shift (,d+[DATE] hours). LVN 5 verified the above findings. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1540 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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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** 47474 Based on interview, medical record review, and facility P&P review, the facility failed to ensure five of five final sampled residents (Residents 13, 23, 77, 83, and 541) reviewed for unnecessary medications were free from the unnecessary psychotropic drugs. * The facility failed to ensure Resident 13's consent for Seroquel (antipsychotic medication) was signed and dated by the physician. * The facility failed to ensure Resident 83's consent for Risperdal (antipsychotic medication) was signed and dated by the physician. * The facility failed to ensure Resident 541 with prescribed Seroquel was monitored for orthostatic hypotension and number of behavior episodes; and provided non-pharmacological interventions. In addition, the facility failed to ensure the physician obtained a consent for the prescribed Seroquel medication and failed to ensure the behavior manifestation in the orders was accurate . * The facility failed to ensure Resident 77 was monitored for adverse side effects including orthostatic hypotension related to the use of Seroquel medication. * Resident 23 who had a diagnosis including dementia (a disorder which causes a progressive decline in memory and behavior that affects the ability to perform everyday activities) was prescribed Seroquel, an antipsychotic medication for psychosis manifested by yelling for no apparent reason. The facility failed to ensure the physician had signed and dated the informed consent for Resident 23's Seroquel. Additionally, the facility failed to ensure the episodes of behavior manifestations were accurately documented, non-pharmacological interventions were implemented prior to administering the Seroquel medication, and monitoring for orthostatic hypotension was completed per Resident 23's plan of care. These failures had the potential to negatively impact the resident's well-being. Findings: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's P&P titled Use of Psychotropic Medications revised 12/2022 showed the residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medications is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medications(s). The P&P further showed a psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: antipsychotics, antidepressants, antianxiety, and hypnotics. The indications for use of any psychotropic drug will be documented in the medical record. Moreover, the P&P showed residents who use psychotropic drugs shall also receive non-pharmacological interventions to facility reduction or discontinuation of the psychotropic drugs and the resident's response to the medication(s), including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record. The effects of the psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis, such as in accordance with nurse assessments and medication monitoring parameters consistent with clinical standards of practice manifactuer's specifications, and the resident's comprehensive plan of care. Review of the facility's P&P titled Informed Consent revised on 12/2022 showed prior to initiating the administration of a psychotherapeutic medication or physical restraint or a device, licensed nursing staff shall verify with the resident or surrogate decision maker that he/she has given informed consent for the proposed psychotherapeutic medication or physical restraint or device to the prescriber. Psychotherapeutic medications may not be administered until informed consent has been verified. 1. Medical record review for Resident 13 was initiated on 10/8/24. Resident 13 was admitted to the facility on [DATE], and readmitted back to the facility on [DATE]. Review of Resident 13's Orders Summary Report dated October 2024 showed the following: - an order dated 4/19/23 to 6/23/23, for Seroquel 25 mg 1/2 (half) tablet by mouth two times a day for acute psychotic disorder m/b unprovoked striking out. Review of Resident 13's Physician Documentation of Informed Consent for Seroquel 25 mg 1/2 tablet by mouth twice daily for acute psychotic disorder m/b unprovoked striking out, undated, showed no documented evidence of the physician's signature or date. On 10/10/24 at 0950 hours, an interview and concurrent medical record review for Resident 13 was conducted with LVN 2. LVN 2 verified the above findings and stated the consent form for the use of Seroquel medication should have been signed and dated by the physician. On 10/10/24 at 1620 hours, an interview was conducted with the Administrator and DON. The Administrator and DON acknowledged above findings. 2. Medical record review for Resident 83 was initiated on 10/8/24. Resident 83 was admitted to the facility on [DATE]. Review of Resident 83's H&P examination dated 8/6/24, showed Resident 83 had no capacity to understand and make decisions. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 83's Orders Summary Report dated October 2024 showed the following: - an order dated 8/3/24, Risperidal (antipsychotic) 0.5 mg one tablet via GT three times a day for psychosis m/b striking out for no apparent reason. Review of Resident 13's Physician Documentation of Informed Consent for Risperidal 0.5 mg three times daily for psychosis m/b striking out at staff showed no documented evidence of the physician's signature or date. On 10/10/24 at 0940 hours, an interview and concurrent medical record review for Resident 83 was conducted with LVN 2. LVN 2 verified the above findings and stated the consent form for the use of Risperidal medication was not signed and dated by the physician but should be. On 10/10/24 at 1620 hours, an interview was conducted with the Administrator and DON. The Administrator and DON acknowledged the above findings. 3. Medical record review for Resident 541 was initiated on 10/8/24. Resident 541 was admitted to the facility on [DATE], and readmitted back to the facility on [DATE]. Review of Resident 541's H&P examination dated 9/30/24, showed Resident 541 had no mental capacity to make medical decisions. Review of Resident 541's Orders Summary Report dated October 2024 showed the following: - an order dated 9/25/24, to monitor for acute psychotic disorder m/b unprovoked striking out every shift for Seroquel use - an order dated 10/2/24, to administer Seroquel 25 mg one tablet by mouth two times a day for acute psychotic disorder m/b uncontrollable crying. * However, Resident 541's physician's orders for the use of Seroquel medication and the monitoring of the Seroquel did not match regarding the behaviors manifestation. The Seroquel medication order showed the manifestation behavior was uncontrollable crying; however, the behavior monitoring order showed the manifestation behavior was unprovoked striking out. * Review of Resident 541's consent for the Seroquel 25 mg 1/2 tablet by mouth BID for acute psychotic disorder showed no documented evidence the physician obtained the consent from the resident or responsible party. Further review of Resident 541's medical record showed no documented evidence an updated consent form for Seroquel 25 mg one tablet was obtained and signed by the physician. * In addition, review of Resident 541's Orders Summary Report dated October 2024 showed no documented evidence Resident 541 was monitored for orthostatic hypotension and episodes of behavior exhibited. There was no documented evidence the non-pharmacological interventions were implemented. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/24 at 1150 hours, an interview and concurrent medical record review for Resident 541 was conducted with LVN 3. LVN 3 verified the consent for Seroquel 25 mg 1/2 tablet by mouth BID was not signed or dated by the physician. LVN 3 also verified the order for Seroquel was changed from Seroquel 25 mg 1/2 tablet to Seroquel 25 mg one tablet on 10/3/24, and acknowledged the facility should have obtained a new consent form for the new Seroquel order. LVN 3 verified there was no documented evidence a consent for Seroquel 25 mg one tablet by mouth BID. LVN 3 sated there should have been a new consent form completed. On 10/10/24 at 1430 hours, an interview and concurrent medical record review for Resident 541 was conducted with LVN 1. LVN 1 verified there were no documented evidence of the resident's orthostatic hypotension monitoring, non-pharmacological interventions, and number of episode behavior monitoring. LVN 1 further verified the m/b noted on the behavior monitoring order and physician's orders did not match. LVN 1 stated assessing the number of episodes of the behavior would show if the medications were effective and provides the physician information if the medications need to be changed or doseage adjusted based on the effectiveness of the medication. Moreover, LVN 1 stated the resident's orthostatic hypotension should be monitored due to the side effects of the psychotropic medications which could affect the blood pressure and non-pharmacological interventions should have also been monitored for Resident 541. On 10/10/24 at 1620 hours, an interview was conducted with the Administrator and DON. The Administrator and DON acknowledged the above findings. 48882 4. Medical record review for Resident 77 was initiated on 10/7/24. Resident 77 was admitted to the facility on [DATE], and readmitted on [DATE], with the diagnosis of unspecified psychosis and major depressive disorder. Review of Resident 77's H&P examination dated 9/20/24, showed Resident 77 had no capacity to understand and make decisions. Review of Resident 77's Order Summary Report dated 10/8/24, showed the following physician's orders: - dated 9/19/24, to monitor psychosis manifested by unprovoked striking and yelling and record the number of times the behavior was manifested every shift. - dated 9/20/24, to administer Seroquel 25 mg one tablet by mouth at bedtime for psychosis manifested by unprovoked striking and yelling. Further review of Resident 77's Order Summary Report failed to show a physician's order to monitor Resident 77 for side effects/adverse effects related to the use of Seroquel medication and failed to show the physician's order to monitor Resident 77 for orthostatic hypotension related to the use of Seroquel medication. Review of Resident 77's MAR for September and October 2024 showed Resident 77 was administered Seroquel 25 mg one tablet by mouth at bedtime from 9/20/24 to 10/8/24 at 2100 hours. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 77's plan of care showed a care plan problem dated 9/18/24, addressing Resident 77's use of psychotropic medication for psychosis manifested by unprovoked striking and yelling. The interventions showed to observe for the adverse reactions: sedation, dizziness, headache, tremors, salivation, sweating, dry mouth, tachycardia (high heart rate), hypotension (low blood pressure), constipation, nausea, fever, and agranulocytosis (that weakens the immune system); to monitor TCAP (Tardive dyskinesia, cognitive changes, akathisia, and parkinsonism) every shift, and to monitor orthostatic blood pressure weekly when sitting and lying. Review of Resident 77's Monitor Record for September 2024 and October 2024 failed to show Resident 77 was monitored for orthostatic hypotension or monitored for the adverse effects related to the use of Seroquel medication. On 10/9/24 at 1049 hours, an interview and concurrent medical record review for Resident 77 was conducted with LVN 7. LVN 7 verified the above findings. On 10/10/24 at 1056 hours, an interview and concurrent medical record review for Resident 77 was conducted with the DON. The DON stated for the residents on antipsychotics, the residents should be monitored for the side effects and orthostatic hypotension related to the use of antipsychotics. The DON reviewed Resident 77's medical record and verified there were no monitoring for the side effects or orthostatic hypotension for Resident 77 related to the use of Seroquel medication. On 10/10/24 at 1556 hours, the Administrator, DON, and Medical Records Assistant were informed and acknowledged the above findings. 47476 5. Medical record review for Resident 23 was initiated on 10/7/24. Resident 23 was admitted to the facility on [DATE]. Review of Resident 23's H&P examination dated 9/15/24, showed Resident 23 had a diagnosis of dementia and had the capacity to understand and make decisions. Review of Resident 23's Physician Documentation of Informed Consent undated showed a proposed treatment for Resident 23 for Seroquel 25 mg one tablet by mouth BID for psychosis. The document failed to show the physician's signature or date. Review of Resident 23's Order Summary Report dated 10/7/24, showed the following physician's orders dated: - 9/14/24, for Seroquel oral tablet 25 mg one table by mouth at bedtime for psychosis manifested by yelling for no apparent reason. This order was discontinued on 9/23/24, - 9/14/24, to monitor for side effects related to use of psychotropic medications every shift. - 9/23/24, for Seroquel oral tablet 25 mg one tablet by mouth two times a day for psychosis manifested by yelling for no apparent reason. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 23's Order Summary Reports failed to show an order for the behavioral monitoring for Resident 23's psychosis and non-pharmacological interventions related to the use of psychotropic medication. Review of Resident 23's plan of care showed a care plan focus initiated 9/14/24, for the use of psychotropic medication for psychosis manifested by yelling for no apparent reason. The interventions included to monitor orthostatic blood pressure every week when sitting and lying. Further review of Resident 23's medical record failed to show Resident 23's orthostatic blood pressure was monitored as per Resident 23's plan of care. On 10/9/24 at 1625 hours, a concurrent interview and medical record review was conducted with RN 3. RN 3 stated Resident 23 was very impulsive and tried to get up without assistance. RN 3 stated Resident 23 was taking Seroquel medication and should be monitored for the behavior manifestation. RN 3 verified there was no documented evidence the behavioral monitoring was being completed for Resident 23's use of Seroquel and stated there should be a separate monitoring order to tally the behaviors. On 10/10/24 at 0808 hours, a concurrent interview and medical record review was conducted with the DON. The DON was informed of the above findings. The DON stated Resident 23 was started on Seroquel on 9/14/24, and the staff should be monitoring the behaviors for the medication. The DON verified there was no documented evidence of the monitoring for Resident 23's yelling behaviors for no apparent reason, no documented evidence of the monitoring for orthostatic hypotension as per Resident 23's care plan; and verified there was no documented evidence of the non-pharmacological interventions implemented as per the facility's P&P. On 10/10/24 at 1357 hours, a follow-up concurrent interview and medical record review was conducted with the DON. The DON verified the physicians should be signing the informed consent when they were in the facility and Resident 23's Physician Documentation of Informed Consent was missing a physician's signature and date.

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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 76) was free from the significant medication errors. * The facility failed to ensure Resident 76 received Keppra (anticonvulsant medication) and metformin (antidiabetic medication) due to leakage from medication cup. This failure had the potential to cause Resident 76 to have convulsion (a medical condition that causes the body to shake uncontrollably), high blood glucose and negatively affect the resident's health. Findings: Review of the facility's P&P titled Medication Administration via Enteral Tube revised 12/19/22, showed the following: - To ensure the safe and effective administration of medications via enteral feeding tubes by utilizing best practices guidelines; - Each medication will be administered separately, not combined, or added to an enteral feeding formula. On 10/8/24 at 0832 hours, medication administration observation and concurrent interview was conducted with LVN 6. LVN 6 was observed preparing Resident 76's medications in each medication cup, unlabeled. LVN 6 was observed administering the morning medications to Resident 76 via the enteral feeding tube. When LVN 6 attempted to pour the liquid medication cup, no clear liquid came out of the medication cup. The clear liquid medication was observed in the medication tray. LVN 6 verified a 5 ml clear liquid medication was not given due to it leaked to the medication tray. LVN 6 was asked if she could identify which medication leaked out to the medication tray and she stated, I don't know which clear liquid medication. It is one of the 5 ml clear medication. LVN 6 stated, I will inform the RN and doctor about one of the medications not given due to it leaked out into the medication tray. I will investigate which medication. Medical record review for Resident 76 was initiated on 10/8/24. Resident 76 was admitted to the facility on [DATE]. Review of Resident 76's H&P examination dated on 3/27/24, showed Resident 76 had no capacity to make medical decisions. Review of Resident 76's Order Summary Report showed the physician's orders as follows: - Keppra (anticonvulsant) Oral Solution 100 mg/ml 5 ml via enteral three times a day for seizures; and - metformin HCl (antidiabetic) Oral Solution 500 mg/5 ml 5 ml via enteral two times a day for Diabetes Mellitus. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/8/24 at 1034 hours, an interview was conducted with the DON. The DON stated, I confirmed that the medication cup leaked. We will change all the medication cups right away. I informed the PA on call for Resident 76's physician regarding one of the medications not given either Keppra or Metformin. The PA ordered for Keppra x 1 dose and to monitor blood glucose. The DON verified one of the medications was not given either Keppra or metformin; however, the DON was unable to identify. The DON was asked if she needed to get an order for laboratory values to check Resident 76 and she replied, I will call again the PA if he can order labs. On 10/10/24 at 1540 hours, an interview was conducted with the DON. The DON was informed and acknowledged the 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. **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 pharmacy services to ensure proper storage, labeling, and disposal of medications. * The facility failed to ensure the expired medications for one nonsampled resident (Resident 740) in Medication Room A's refrigerator were discarded. * The facility failed to ensure the expired medications were removed from the current treatment supply in Treatment Cart A. * 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 the medication bottles and medication tray were kept clean and free of sticky residue in Medication Cart A. * The facility failed to properly label the opened medications with the open date in Medication Cart A. * The facility failed to ensure the orally administered medications were stored separate from externally used medications in Medication Cart C. * The facility failed to ensure the medications for two of 19 final sampled residents (Resident 12 and 291) in Medication Cart C was labeled with an open date. These failures had the potential to negatively impact the residents' well-being, and the potential for the medications to lose the stability and effectiveness. Findings: Review of the facility's P&P titled Medication storage revised on 12/19/22, showed the following: - External Products: Disinfectants and drugs for external use are stored separately from internal and injectable medications; - Internal Products: Medications to be administered by mouth are stored separately from other formulations (i. e. eye drops, ear drops, injectables); - Unused Medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with facility policy. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's P&P titled Medication Administration revised on 12/19/22, showed the following: - Keep medication cart clean, organized, and stocked with adequate supplies; - Identify expiration date. If expired, notify nurse manager; - Sign MAR after administered; - If medication is a controlled substance, sign narcotic book; and - Correct any discrepancies and report to nurse manager. 1. On 10/9/24 at 0827 hours, a medication room inspection for Medication Room A was conducted with LVN 1. The following was observed: - Two bags of ertapenem (antibiotic medication) 500 mg/NS (normal saline) intravenous for Resident 740 inside the refrigerator, with expiration dates of 10/3 and 10/4/24. LVN 1 verified the above findings. 2. On 10/9/24 at 0900 hours, a medication cart inspection for Treatment Cart A was conducted with LVN 4. The following was observed: - 125 packets of Bacitracin Zinc (used to prevent skin infections caused by small cuts, scrapes or burns) ointment with an expiration date of 8/2024. - 42 packets of hydrocortisone (used to relieve skin itching and redness) cream with an expiration date of 10/2024. - one packet of triple antibiotic (used to prevent skin infections caused by small cuts, scrapes or burns) ointment with an expiration date of 9/2024. LVN 4 verified the above findings. LVN 4 stated the expired medications should not be administered due to the possible adverse effects. 3. On 10/9/24 at 1433 hours, a medication cart inspection for Medication Cart A was conducted with LVN 7. The following was observed: - two containers of nitroglycerin (used to treat and prevent chest pain) tablets were stored with three boxes of artificial tears. - a bottle of extra strength of stool softener (used to prevent constipation) 250 mg tablets was stored with five tubes of diclofenac (used for pain relief) topical cream. - a tube of muscle rub cream (used to treat muscle pain) and psyllium husk powder (laxative medication) were stored with a box of bisacodyl suppository (laxative) and a box Restasis (used to treat chronic dry eyes) eye drops. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- a box of Lovenox (anticoagulant medication) injection and Lidocaine (local anesthetic medication) patches stored with a box of Arginaid powder (amino acid supplement). - a box of Heparin (anticoagulant medication) injection stored with two boxes of alendronate (used to prevent bone fractures) tablets and one box of Imodium (antidiarrheal medication). - one container of Airoma linen breeze air freshener was stored with liquid medications. - a bottle of Geri-Tussin DM (cough medication) and a bottle of docusate sodium (stool softener medication) with pinkish-white sticky residue outside the bottle; and one blue medication tray with pinkish sticky residue. - an opened box of loperamide hcl (antidiarrheal medication) 2 mg tablet with no open date was stored with four boxes of ipratropium (medication used to help open the airways in the lungs) and naloxone HCl (used to treat narcotic overdose). - a bottle of tobramycin (antibiotic medication) and dexamethasone ophthalmic (used to treat swelling, redness and irritation in the eyes) suspension 0.3%/0.1% with no open date. LVN 7 verified the above findings. 4. On 10/9/24 at 1034 hours, a medication cart inspection for Medication Cart C was conducted with LVN 5. The following was observed: - One bottle of [NAME] shell calcium (supplement) 500 mg tablets was stored with one opened box of bisacodyl suppository containing seven suppositories and two tubes of diclofenac cream. - One opened box of budesonide-formoterol fumarate (medication used to help open the airways in the lungs) inhalation aerosol 160 mcg/4.5 mcg for Resident 291 was observed without an open date. - One bottle of morphine sulfate (opiate analgesic medication) oral solution 5 mg/0.25 ml of Resident 12 was observed without an open date. LVN 5 verified the above findings. LVN 5 stated the medications with different routes should not be stored together. On 10/10/24 at 1540 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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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 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. 43119 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 kitchen utensils had a smooth cleanable surface and in good condition. * The facility failed to ensure the kitchen utensils were clean and free of food particle or residue. * The facility failed to ensure the heavy-duty blenders used for puree preparation were air dried prior to storing. * The facility failed to ensure the sanitary condition of the hood over the stove was maintained. These failures had the potential for cross contamination and foodborne illnesses to the residents consuming the foods prepared in the facility's kitchen. Findings: Review of the facility's Diet Type Report dated 10/8/24, showed 87 of 95 residents consumed the foods prepared in the kitchen. 1. Review of the facility's P&P titled Dish and Utensil Procedure revised date 3/3/20, showed chipped or cracked dishes, trays shall be discarded. According to the USDA Food Code 2022 Section 4-502.11 Good Repair and Calibration, (A) Utensils shall be maintained in a state of repair and condition that complies with the requirements specified under Parts 4-1 and 4-2 or shall be discarded. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 10/7/24 at 0808 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the DSS. The following was observed: - One white plastic spatula was chipped, discolored, and worn. - Two white plastic spoons were chipped and discolored with burnt marks and partially melted on the edges. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- One red rubber spatula was chipped with a partially melted handle. - One black peeler had yellowish/orange discoloration on the metal part which resembled rust. - One stainless serving scoop with green handle was dry with crusted residue, and the handle was discolored and partially melted. The DSS verified the above findings and stated the spatulas, peeler, and serving scoop should not be used because it was a hazard and could be mixed with food. 2. Review of the facility's P&P titled Dish and Utensil Procedure revised date 3/3/20, showed any dish, tray or utensil with debris should not be used. Send back to the dish room to be properly washed and sanitized. Dishes, trays, and utensils shall be routinely checked for stains or spots. According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2017, 4-602.13, Non- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On 10/7/24 at 0808 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the DSS, the following was observed: - Two stainless tongs had dry and crusted residue. - One stainless measuring cup had dry and crusted residue. - Three stainless slotted serving spoons had dry and crusted residue. - Two stainless serving spoons had dry and crusted residue. - One stainless serving scoop with green handle had dry and crusted residue. - One scoop with green handle used for food portioning had dry and crusted residue. - One scoop with white handle used for food portioning had orange discoloration on the bottom part of the handle. The DSS acknowledged the above findings and stated all should not be used, it should be cleaned and washed to prevent cross contamination. 3. Review of the facility's P&P titled Dish and Utensil Procedure revised date 3/3/20, showed dishes, trays, and utensils shall be air dried before storage. Do not towel dry. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the USDA Food Code 2022, 4-901.11, Equipment and Utensils, Air-Drying Required, that after cleaning and sanitizing, equipment, and utensils shall be air-dried or used after adequate draining before getting in contact with food. According to the USDA Food Code 2022, 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, cleaned equipment and utensils shall be stored in a self-draining position that allows air drying. On 10/7/24 at 0808 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the DSS. Two heavy-duty blenders stored on the counter shelves were still wet with visible water inside. The DSS verified the above findings and stated it was supposed to be air dried. 4. According to the USDA Food Code 2022 Section 4-204.11 Ventilation Hood Systems, Drip Prevention. The dripping of grease or condensation onto food constitutes adulteration and may involve contamination of the food with pathogenic organisms. Equipment, utensils, linens, and single service and single use articles that are subjected to such drippage are no longer clean. On 10/7/24 at 0808 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the DSS. The kitchen hood had black, dirt residue. The DSS acknowledged the above finding and stated the dietary staff cleaned the hood twice a month and an outside company performed service for the kitchen hood last 9/24. The DSS further stated the dust or grease should not be found on the kitchen hood to prevent fire hazards.

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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. 43119 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the use and storage of food brought to the facility by the family members or visitors. This failure had the potential to cause foodborne illnesses to the medically vulnerable resident population who consume food brought from outside sources. Findings: Review of the CMS S&C-09-39 dated 5/29/09, showed the residents have the rights to choose to accept food from visitors, family, friends, or other guests according to their rights to make choices. Review of the State regulations dated 2/3/23, showed the facility must have a policy regarding use and storage of foods brought to the residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. Review of the facility's P&P titled Use and Storage of Food Brought in by Family or Visitors revised 1/25/24, showed it is the right of the residents of this facility to have food brought in by family or other visitors, however, the food must be handled in a way to ensure the safety of the resident. The P&P further showed all food items that are already prepared by the family or visitor brought in must be approved per Nursing to ensure is in accordance with the Diet Order and eaten within two hours of receiving and all remaining food must be discarded. On 10/7/24 at 0908 hours, an interview with the DSS was conducted. The DSS stated the facility did not have a resident's refrigerator. The DSS further stated the food brought from outside were for immediate consumption within two hours and leftovers were discarded. On 10/9/24 at 1443 hours, an interview was conducted with the RD. The RD acknowledged the above findings and stated the facility did not have a refrigerator designated for the residents. On 10/9/24 at 1420 hours, an interview was conducted with the DON. The DON acknowledged the above findings and stated food brought from outside were for immediate consumption within two hours and the facility did not have a refrigerator designated for the residents. The DON further stated they discouraged family from bringing in perishable food due to molds and it attracts insects. The DON acknowledged the facility P&P did not address if the resident or the responsible party prefer to eat the food in the later time or more than two hours, where the food will be stored.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47476 Based on interview and medical record review, the facility failed to ensure the complete and accurate medical records for seven of 19 final sampled residents (Residents 12, 13, 49, 62, 87, 291, and 541). * Resident 541's POLST was incomplete and did not show for an advance directive information. * Resident 291's medical record contained conflicting information as to whether Resident 291 had formulated an advance directive. * Resident 49's medical record contained conflicting information as to whether Resident 49 had formulated an advance directive. * The facility failed to ensure Resident 87's TAR for October 2024 was accurate. * The facility failed to ensure Resident 12's consent for side rails use was complete. * The facility failed to ensure Resident 13's consent for the bilateral half side rails had the physician's signature and date. * The facility failed to ensure Resident 62's consents for the Ativan, trazodone, depakote and mirtazapine medications had the physician's signature. These failures resulted in incomplete and inaccurate medical records. Findings: 1. Medical record review for Resident 541 was initiated on 10/7/24. Resident 541 was readmitted to the facility on [DATE]. Review of Resident 541's Physician Orders for Life-Sustaining Treatment (POLST) dated 10/3/24, under Section D - Information and Signatures showed the advance directive information was left blank. On 10/8/24 at 1428 hours, a concurrent interview and medical record review was conducted with the SSD. The SSD verified Resident 541's POLST was incomplete and did not show the advance directive information. On 10/8/24 at 1544 hours, a concurrent interview and medical record review was conducted with RN 1. RN 1 verified Resident 541's POLST was incomplete and did not state if the resident did or did not have an advance directive available. 37726 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Medical record review for Resident 291 was initiated on 10/7/24. Resident 291 was admitted to the facility on [DATE]. Review of Resident 291's Physician Orders for Life-Sustaining Treatment (POLST) dated 9/25/24, showed Resident 291's advance directive was not available. However, review of Resident 291's Advance Directive Acknowledgment form dated 9/29/24, showed Resident 291 had not executed an advance directive. On 10/8/24 at 1439 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD verified the discrepancy specific to if Resident 291 had formulated an advance directive. The SSD stated the information documented on Resident 291's POLST dated 9/25/24, specific to whether Resident 291 had formulated an advance directive was inaccurate. 3. Medical record review for Resident 49 was initiated on 10/7/24. Resident 49 was admitted to the facility on [DATE]. Review of Resident 49's POLST dated 8/26/19, showed Resident 49's advance directive was not available. However, review of Resident 49's Advance Directive Acknowledgement form dated 1/16/24, showed Resident 49 had not executed an advance directive. On 10/8/24 at 1439 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD verified the discrepancy specific to if Resident 49 had formulated an advance directive. The SSD stated the information documented on Resident 49's POLST dated 8/26/19, specific to whether Resident 40 had formulated an Advance Directive was inaccurate and documented in error. 48882 4. Medical record review for Resident 87 was initiated on 10/7/24. Resident 87 was admitted to the facility on [DATE]. Review of Resident 87's H&P examination dated 9/11/24, showed Resident 87 had the capacity to understand and make decisions. Review of Resident 87's Order Summary Report dated 10/9/24, showed the following physician's orders dated 10/3/24: - Stage 1 pressure injury (intact skin with non-blanchable redness of a localized area usually over a bony prominence) to the left heel, to cleanse with normal saline, pat dry, apply swab with skin prep and leave open to air, every day for 21 days. - Stage 1 pressure injury to the right heel, to cleanse with normal saline, pat dry, apply swab with skin prep and leave open to air, every day for 21 days. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 87's TAR for October 2024 showed the treatment was provided to Resident 87's left and right heels from 10/8/24 to 10/10/24, during the 0700 to 1500-hour shift. However, there were no documentation the wound treatments for the left and right heels were administered from 10/3/24 to 10/7/24, for the 0700 to 1500 hours shift. On 10/10/24 at 1034 hours, an interview and concurrent medical record review for Resident 87 was conducted with LVN 4. LVN 4 stated for the residents with wounds, the physician ordered the treatment orders and carried out by the treatment nurses. LVN 4 stated after the wound care were administered to the resident, she would sign on the TAR that the treatment was administered. LVN 4 further stated when the treatments were not signed, there should be documentation in the progress notes to indicate the reason the treatment was not provided. When asked about Resident 87, LVN 4 stated Resident 87 was compliant and did not refuse treatments. Concurrent review of Resident 87's TAR for October 2024 was conducted with LVN 4. LVN 4 verified the above findings. LVN 4 stated she worked from 10/3 to 10/7/24,and the treatments were administered to Resident 87's left and right heels as ordered. LVN 4 further stated the treatments should have been signed off after the treatments were administered. On 10/10/24 at 1556 hours, the Administrator, DON, and Medical Records Assistant were informed and acknowledged the above findings. 50967 5. Medical record review for Resident 12 was initiated on 10/8/24. Resident 12 was readmitted to the facility on [DATE]. Review of Resident 12's H&P examination dated 2/29/24, showed Resident 12 had the capacity to understand and make decisions. Review of Resident 12's Order Summary Report showed a physician's order dated 8/7/24, for bilateral half side rails for bed mobility and enabler. Review of Resident 12's Physician Documentation Informed Consent for the bilateral half side rails showed the physician obtained and signed the informed consent form. However, the section to show whether the resident or the responsible party consented to the order was left unchecked. On 10/9/24 at 1322 hours, an interview and concurrent facility document review was conducted with LVN 3. LVN 3 verified the above finding. LVN 3 stated the informed consent form needed to be complete, to show who the consent was obtained from. On 10/10/24 at 1540 hours, an interview was conducted with the DON. The DON stated the Physician Documentation Informed Consent must be completed upon receiving a physician's order for the side rails. The DON was informed and acknowledged the above findings. 6. Medical record review for Resident 13 was initiated on 10/8/24. Resident 13 was readmitted to the facility on [DATE]. Review of Resident 13's MDS dated [DATE], showed Resident 13's BIMS score was 11 (meaning moderate cognitive impairment). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 13's Order Summary Report showed a physician's order dated 6/4/24, for bilateral half side rails for bed mobility and transfer. Review of Resident 13's Physician Documentation Informed Consent for the bilateral half side rails did not show the physician's signature and date. On 10/9/24 at 1322 hours, an interview and concurrent facility document review was conducted with LVN 3. LVN 3 verified the above finding. LVN 3 stated the physician needed to be informed by the facility staff to sign the informed consent form. 7. Medical record review for Resident 62 was initiated on 10/9/24. Resident 62 was readmitted to the facility on [DATE]. Review of Resident 62's H&P examination dated 3/28/24, showed Resident 62 had no capacity to make decisions. Review of Resident 62's Order Summary Report showed the following physician's orders: - dated 11/6/23, to administer Ativan (antianxiety medication) 0.5 mg one tablet by mouth every six hours for anxiety (intense, excessive, and persistent worry and fear about everyday situations) m/b inability to relax. - dated 11/6/23, to administer trazodone HCl (antidepressant) 100 mg one tablet by mouth at bedtime for insomia m/b inability to sleep. - dated 7/14/24, to administer depakote (used to treat seizures and bipolar disorder- mood swings ranging from depressive lows to manic highs) 125 mg one capsule by mouth one time a day for bipolar disorder m/b screaming. - dated 7/30/24, to administer mirtazapine (antidepressant) 7.5 mg one tablet by mouth at bedtime for depression m/b withdrawal from activities. Review of Resident 62's Facility Verification of Informed Consent dated 7/17/24, showed the facility staff verified the physician obtained the informed consent from the responsible party for the Ativan, trazodone, depakote and mirtazapine medications. However, review of Resident 62's Physician Documentation Informed Consents for the Ativan, trazodone, depakote and mirtazapine medications did not show the physician's signature. On 10/10/24 at 1415 hours, an interview was conducted with the DON. The DON verified the above findings for Residents 13 and 62. The DON stated the medical record staff would prepare all the residents' charts for the physician to sign on their next visit and placed a sign here tab for to indicate where the physician needed to sign. The DON stated if the physician did not sign the consent after the first visit, the Medical Record Director (MRD) would follow up or call the physician. The DON also stated the expectation for the physicians was to sign the informed consents as soon as possible. On 10/10/24 at 1540 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47476 Based on interview, medical record review, and facility P&P review, the facility failed to ensure two of five final sampled residents (Residents 23 and 80) reviewed for vaccinations were assessed for the COVID-19 vaccination status or offered the COVID-19 vaccine. This failure put the residents at risk for increased risk of infection and transmission of COVID-19. Findings: Review of the facility's P&P titled COVID-19 Vaccination revised 6/9/23, showed it is the policy of the facility to minimize the risk of acquiring, transmitting, or experiencing complications from COVID-19 by educating and offering the residents and staff the COVID-19 vaccine. The COVID-19 vaccinations will be offered to the residents when the supplies are available, as per CDC and/or FDA guidelines unless such immunization is medically contraindicated, the individual has already been immunized during this time period or refuses to receive the vaccine. 1. Medical record review for Resident 23 was initiated on 10/7/24. Resident 23 was admitted to the facility on [DATE]. Review of Resident 23's medical record failed to show the COVID-19 vaccination status of the resident or if the facility had offered the COVID-19 vaccine. 2. Medical record review for Resident 80 was initiated on 10/7/24. Resident 80 was admitted to the facility on [DATE]. Review of Resident 80's Immunization record (undated) showed the informed consent was obtained from the resident by the IP on 7/1/24, for the COVID-19 vaccination. The notes section showed Resident 80 was currently on antibiotics and wanted to wait to receive the vaccine after the antibiotic was completed. Review of Resident 80's medical record failed to show documented evidence Resident 80 was re-offered and received the COVID-19 vaccine after the anitbiotic treatment was completed. On 10/9/24 at 1318 hours, a concurrent interview and medical record review was conducted with the IP. The IP verified the above findings.

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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. 50967 Based on observation, interview, and facility document review, the facility failed to ensure the essential equipment was maintained in safe operating condition. * The facility failed to ensure the glucometer quality control test was done and the results were accurately documented for two of two glucometer devices reviewed. This failure had the potential for the residents requiring glucose checks to have inaccurate readings. Findings: 1. On 10/9/24 at 1433 hours, a review of the Assure Platinum Glucose Monitoring System: Quality Control Record for October 2024 for Medication Cart A was conducted with LVN 7. The log showed the following: - on 10/8/24, the normal control result was 88 mg/dL and the high control result was 230 mg/dL. - on 10/9/24, the normal control result was 87 mg/dL and the high control result was 226 mg/dL. However, the above normal control and high control results were not observed on the glucometer device. LVN 7 verified the above findings. LVN 7 stated the 11-7 shift licensed nurses were responsible to perform and document the glucometer quality control test every night shift. 2. On 10/10/24 at 0740 hours, a review of the Assure Platinum Glucose Monitoring System: Quality Control Record for October 2024 for Medication Cart C was conducted with LVN 5. The log showed following: - on 10/2/24, the normal control result was 96 mg/dL and the high control result was 241 mg/dL. - on 10/3/24, the normal control result was 97 mg/dL and the high control result was 238 mg/dL. - on 10/4/24, the normal control result was 96 mg/dL and the high control result was 224 mg/dL. - on 10/5/24, the normal control result was 90 mg/dL and the high control result was 199 mg/dL. - on 10/6/24, the normal control result was 100 mg/dL and the high control result was 224 mg/dL. - on 10/9/24, the normal control result was 95 mg/dL and the high control result was 235 mg/dL. However, the above normal control and high control results were not observed on the glucometer device. LVN 5 verified the above findings. LVN 5 stated the 11-7 shift licensed nurses were responsible to perform and document the glucometer quality control every night shift. On 10/10/24 at 1430 hours, an interview was conducted with the DON. When asked how often the licensed nurses were to perform and document the glucometer quality control test, the DON stated the facility's expectation was for the licensed nurses to complete every night shift. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/24 at 1540 hours, a follow-up interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 50967 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 accurate and complete for 15 of 15 residents (14 final sampled residents, Residents 12, 13, 23, 33, 44, 47, 49, 77, 80, 83, 85, 87, 540, and 541 and one nonsampled resident, Resident 24) reviewed for side rail use. This failure 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. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's P&P titled Proper Use of Bed Rails dated on 12/19/22, showed the facility to utilize a person-centered approach when determining the use of side rails. Appropriate alternative approaches are attempted prior to installing or using bed rails. If bed rails are used, the facility ensures correct installation, use and maintenance of the rails. The resident assessment must also assess the resident's risk from using bed rails. Example of potential risks with the use of side rails include accident hazards like entrapment. The resident assessment should Assess the resident's risk of entrapment between the mattress and the bed rail or in bed rail itself. The facility will assure the correct installation and maintenance of bed rails, prior to use. Ensuring that the bed's dimensions are appropriate for the resident by inspecting and regularly checking the mattress and bed rails for areas of possible entrapment. Enduring bed frame, bed rail and mattress do not leave a gap wide enough to entrap a resident's head or body, regardless of mattress width, length, and/or depth. The Maintenance Director or designee is responsible for adhering to a routine maintenance and inspection schedule for all bed frames, mattresses, and bed rails. Review of the facility's Bed System Measurement Device Test Result Worksheet did not show Zones 1, 6, and 7 for entrapment assessment. 1. On 10/7/24 at 0908 hours, an observation and concurrent interview was conducted with LVN 8. Resident 12 was observed sitting up in the wheelchair. Resident 12's bilateral half side rails were elevated. LVN 8 verified Resident 12's bilateral half side rails were elevated. LVN 8 stated Resident 12 used the bilateral half side rails to assist with turning during care. Medical record review for Resident 12 was initiated on 10/8/24. Resident 12 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 12's H&P examination dated 2/29/24, showed Resident 12 had the capacity to understand and make decisions. Review of Resident 12's Order Summary Report showed a physician's order dated 8/7/24, for bilateral half side rails for bed mobility and enabler. Review of the Resident 12's Bed System Measurement Device Test Result Worksheet dated 8/7/24, showed Zone 3 was checked and P was encircled for Pass. However, the worksheet did not show if Zones 1, 6, and 7 were assessed for the risk of entrapment. 2. On 10/7/24 at 0826 hours, an observation and concurrent interview was conducted with CNA 8 and Resident 13. Resident 13 was lying in bed with the bilateral half side rails elevated. CNA 8 verified Resident 13's bilateral half side rails were elevated. Resident 13 stated he used the side rails to assist with repositioning and transfer from bed to his wheelchair. Medical record review for Resident 13 was initiated on 10/8/24. Resident 13 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 13's H&P examination dated 10/1/24, did not show if Resident 13 had the capacity to understand and make decisions. Review of Resident 13's MDS dated [DATE], the Section C showed a BIMS score of 11 (moderate cognitive impairment). (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 13's Order Summary Report showed a physician's order dated 6/4/24, for bilateral half side rails for bed mobility and transfer. Review of Resident 13's Bed System Measurement Device Test Result Worksheet dated 6/4/24, showed Zone 3 was checked and P was encircled for Pass. However, the worksheet did not show if Zones 1, 6, and 7 were assessed for the risk for entrapment. 3. On 10/8/24 at 1143 hours, an observation and concurrent interview was conducted with CNA 7. Resident 47 was observed lying in bed with the bilateral half side rails elevated. CNA 7 verified Resident 47's bilateral half side rails were elevated. CNA 7 stated Resident 47 used the bilateral half side rails to assist with turning during care. Medical record review for Resident 47 was initiated on 10/8/24. Resident 47 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 47's H&P examination dated 11/6/23, did not show if Resident 47 had the capacity to understand and make decisions. Review of Resident 47's MDS dated [DATE], the Section C, showed an interview cannot be conducted. Review of Resident 47's Order Summary Report showed a physician's order dated 7/31/24, for bilateral half side rails for bed mobility and transfer. Review of Resident 47's Bed System Measurement Device Test Result Worksheet dated 7/31/24, showed Zone 3 was checked and P was encircled for Pass. However, the worksheet did not show if Zones 1, 6, and 7 were assessed for the risk for entrapment. On 10/9/24 at 0944 hours, an interview and concurrent facility document review was conducted with the Maintenance Director. The Maintenance Director verified he did not document the Zones 1, 6, and 7 on the Bed System Measurement Device Test Result Worksheet. The Maintenance Director verified the worksheet did not show Zones 1, 6, and 7. On 10/10/24 at 1540 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 50787 4. On 10/7/24 at 1000 hours, Resident 24 was observed lying in bed holding to both elevated side rails. Resident 24 stated he used the rails to assist in his turning, positioning, and exercising. On 10/9/24 at 0800 hours, an interview was conducted with CNA 7. CNA 7 stated Resident 24 used the side rails to move around. Medical record review for Resident 24 was initiated on 10/9/24. Resident 24 was admitted to the facility on [DATE]. Review of Resident 24's Quarterly MDS dated [DATE], showed Resident 24's BIMS score was 7 (severe cognitive impairment). (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 24's Order Summary Report dated 9/30/24 showed a physician's order dated 9/23/23, for the use of bilateral half side rails for bed mobility and transfer use. Review of Resident 24's Bed Rails Annual assessment dated [DATE], showed the indications for the side rail use was for mobility/transfer purposes and Resident 24 demonstrated the ability to use the equipment as an enabler. Review of Resident 24's Restrictive Measures- Risk/Benefits dated 9/27/23, showed the bilateral half side rails for mobility and transfer. Review of Resident 24's Bed System Measurement Device Test Results Worksheet dated 9/29/24, showed Zones 2, 3, and 4 were checked and indicated P (Pass), however, the worksheet did not show if Zones 1, 6, and 7 were assessed for the risk for entrapment. On 10/9/24 at 0920 hours, an interview was conducted with the Maintenance Director. The Maintenance Director stated a measuring tape was used to measure the side rails and bed frame for the risk of entrapment and for the half side rails, Zones 1, 3, 6 and 7 are measured. The Maintenance Director verified the completed Bed System Measurement Device Test form only showed the Zones 2, 3, and 4 and did not show the Zones 1, 6, and 7. On 10/10/24 at 1518 hours, the Administrator and DON were made aware and verified the above findings. 5. On 10/07/24 at 0949 hours, an observation and concurrent interview was conducted with Resident 44. Resident 44 was observed lying in bed with bilateral side rails elevated. Resident 44 stated he used the rails when assisted to the side lying position. Medical record review for Resident 44 was initiated on 10/8/24. Resident 44 was admitted to the facility on [DATE]. Review of Resident 44's Quarterly MDS dated [DATE], showed Resident 44's BIMS score was 5 (severe cognitive impairment). Review of Resident 44's Order Summary Report dated 9/30/24, showed physician's order date of 9/8/23, for the use of the bilateral half side rails for bed mobility and transfer. Review of Resident 44's Restrictive Measures- Risk/Benefits dated 8/17/24, showed bilateral half side rails for mobility and transfer. Review of Resident 44's Bed Rails Annual assessment dated [DATE], showed the indications for the side rail use was for mobility/transfer purposes and Resident 44 demonstrates the ability to use equipment as an enabler. Review of Resident 44's Bed System Measurement Device Test Results Worksheet dated 9/8/24, showed the Zones 2, 3, and 4 were checked and indicated P (Pass). However, the worksheet did not show if the Zones 1, 6, and 7 were assessed for the risk for entrapment. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/9/24 at 0920 hours, an interview was conducted with the Maintenance Director. The Maintenance Director stated a measuring tape was used to measure the side rails and bed frame for the risk of entrapment and for the half side rails, Zones 1, 3, 6 and 7 are measured. The Maintenance Director verified the completed Bed System Measurement Device Test form only showed the Zones 2, 3, and 4 and did not show Zones 1, 6, and 7. On 10/10/24 at 1518 hours, the Administrator and DON were made aware and verified the above findings. 6. On 10/7/24 at 1500 hours, Resident 85 was observed lying in bed with bilateral side rails elevated. On 10/9/24 at 1323 hours, an interview was conducted with CNA 10. CNA 10 verified Resident 85 used the bilateral side rails. Medical record review for Resident 85 was initiated on 10/8/24. Resident 85 was admitted to the facility on [DATE]. Review of the Resident 85's Quarterly MDS dated [DATE], showed Resident 85's BIMS score was 11 (moderate cognitive impairment). Review of Resident 85's Order Summary Report dated 10/9/24, showed a physician's order dated 9/8/24, for bilateral half siderails for mobility and transfer use. Review of Resident 85's Bed Rails assessment dated [DATE], showed the side rail indications are for mobility/transfer and Resident 85 demonstrated the ability to use as an enabler Review of Resident 85's Bed System Measurement Device Test Result Worksheet dated 9/29/24, showed the Zones 2, 3, and 4 were checked and indicated P (Pass). However, the worksheet did not show if Zones 1, 6, and 7 were assessed for the risk for entrapment. On 10/9/24 at 0920 hours, an interview was conducted with the Maintenance Director. The Maintenance Director stated a measuring tape was used to measure the side rails and bed frame for the risk of entrapment and for the half side rails, Zones 1, 3, 6 and 7 are measured. The Maintenance Director verified the completed Bed System Measurement Device Test form only showed the Zones 2, 3, and 4 and did not show the Zones 1, 6, and 7. On 10/10/24 at 1518 hours, the Administrator and DON were made aware and verified the above findings. 47476 7. On 10/7/24 at 0830 hours, Resident 23's bed was observed with bilateral half side rails elevated. Medical record review for Resident 23 was initiated on 10/7/24. Resident 23 was admitted to the facility on [DATE]. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 23's H&P examination dated 9/15/24, showed Resident 23 had a diagnosis of dementia and had the capacity to understand and make decisions. Review of Resident 23's Order Summary Report dated 10/7/24, showed a physician's order dated 9/24/24 for half bilateral side rails for mobility and enabler. Review of Resident 23's MDS dated [DATE], showed Resident 23's BIMS score was 3, indicating severe cognitive impairment. Review of Resident 23's Restrictive Measures- Risks/Benefits dated 9/14/24, showed the half bilateral side rails were indicated for bed mobility and transfer. Review of Resident 23's Bed System Measurement Device Test Result Worksheet dated 9/14/24, showed Zones 2, 3, and 4 were checked and P was circled for Pass. However, the worksheet did not show if Zones 1, 6, and 7 were assessed for the entrapment risk. On 10/8/24 at 1027 hours, a concurrent observation and interview was conducted with CNA 3. CNA stated Resident 23 required supervision and used the side rails for mobility. On 10/9/24 at 1625 hours, an interview was conducted with RN 3. RN 3 stated Resident 23 was very impulsive and tries to get out of bed without assistance. RN 3 stated Resident 23 used the side rails for bed mobility, to help with transfer, and as an enabler. 8. On 10/7/24 at 0840 hours, Resident 541's bed was observed with bilateral half side rails elevated. Medical record review for Resident 541 was initiated on 10/7/24. Resident 541 was readmitted to the facility on [DATE]. Review of Resident 541's H&P examination dated 9/27/24, showed Resident 541 did not have the mental capacity to make medical decisions. Review of Resident 541's Order Summary Report dated 10/8/24, showed a physician's order dated 9/24/24, for half bilateral side rails for bed mobility and enabler. Review of Resident 541's Restrictive Measures- Risks/Benefits dated 9/17/24, showed the half bilateral side rails were indicated for bed mobility and enabler use. Review of Resident 541's Bed System Measurement Device Test Result Worksheet dated 9/24/24, showed Zones 2, 3, and 4 were checked and P was circled for Pass. However, the worksheet did not show if Zones 1, 6, and 7 were assessed for the entrapment risk. On 10/8/24 at 1006 hours, a concurrent observation and interview was conducted with CNA 3. CNA 3 stated Resident 541 used the bilateral side rails for repositioning. On 10/8/24 at 1051 hours, a concurrent observation, interview, and medical record review was conducted with RN 1. RN 1 stated Resident 541 used the side rails for transfer and mobility and the Maintenance assessed for risk of entrapment. (continued on next page)

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	555536	A. Building B. Wing	10/10/2024

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Park Regency Care Center	1770 W. LA Habra Blvd. LA Habra, CA 90631

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. On 10/7/24 at 0847 hours, Resident 540's bed was observed with bilateral one fourth side rails elevated. Medical record review for Resident 540 was initiated on 10/7/24. Resident 540 was admitted to the facility on [DATE]. Review of Resident 540's H&P examination dated 10/4/24, showed Resident 540 had the capacity to understand and make decisions. Review of Resident 540's Order Summary Report dated 10/7/24, showed a physician's order dated 10/2/24 for half bilateral side rails for mobility and transfer. Review of Resident 540's Restrictive Measures- Risks/Benefits dated 10/2/24, showed the half bilateral side rails were indicated for bed mobility and transfer. Review of Resident 540's Bed System Measurement Device Test Result Worksheet dated 10/2/24, showed Zones 2, 3, and 4 were checked and P was circled for Pass. However, the worksheet did not show if Zones 1, 6, and 7 were assessed for the entrapment risk. On 10/8/24 at 1043 hours, an interview was conducted with CNA 3. CNA 3 stated Resident 540 used the side rails for repositioning. On 10/9/24 at 0941 hours, an interview and concurrent facility document review was conducted with the Maintenance Director. The Maintenance Director stated he checked the beds quarterly. The Maintenance Director stated he would need an order from the nurse in order to place side rails and would document the entrapment assessment on the facility document titled, Bed System Measurement Device Test Results Worksheet. The Maintenance Director verified the facility document only assessed for the entrapment zones 2, 3, and 4 and verified there were no measurements for Zones 1, 6 and 7 on the entrapment assessment. On 10/10/24 at 1506 hours, the DON and Administrator were informed and acknowledged the above findings. 43119 10. Medical record review for Resident 33 was initiated on 10/7/24. Resident 33 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 33's H&P examination dated 11/18/23, showed Resident 33 had the capacity to understand and make decisions. Review of Resident 33's Quarterly MDS dated [DATE], showed Resident 33 had a BIMS score of 14 (13-15 suggests intact cognition). Review of Resident 33's Order Summary Report showed a physician's order dated 12/21/23, for bilateral half side rails for mobility use. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/7/24 at 1026 hours, an observation was conducted with Resident 33. Resident 33 was observed lying in bed with bilateral half side rails elevated. On 10/8/24 at 1113 hours, an observation and concurrent interview was conducted with Resident 33. Resident 33 was observed sitting up in the wheelchair. Resident 33 stated she utilized the side rails to reposition and pull herself up in bed. On 10/9/24 at 0941 hours, an interview and concurrent record review was conducted with the Maintenance Director. The Maintenance Director stated when side rails were ordered for a resident, he then conducted a bed/side rail inspection, which included obtaining measurements to identify the potential areas of entrapment, within the seven zones. The Maintenance Director stated the measurements obtained from each zone were documented on the facility's Bed System Measurement Device Test Results Worksheet. Review of Resident 33's Bed System Measurement Device Test Results Worksheet dated 12/21/23, failed to show measurements for Zones 1, 6, and 7. The Maintenance Director verified the findings. On 10/9/24 at 1647 hours, the Administrator and DON were informed and acknowledged the above findings. 11. Medical record review for Resident 83 was initiated on 10/7/24. Resident 83 was admitted to the facility on [DATE]. Review of the Resident 83's H&P examination dated 8/6/24, showed Resident 83 had a diagnosis of Alzheimer's disease and had no capacity to understand and make decisions. Review of Resident 83's Order Summary Report dated 10/8/24, showed a physician's order dated 8/3/24, for bilateral half side rails as an enabler and for mobility. On 10/7/24 at 1012 hours, an observation was conducted with Resident 83. Resident 83 was observed lying in bed with the bilateral half side rails elevated. On 10/9/24 at 0941 hours, an interview and concurrent record review was conducted with the Maintenance Director. The Maintenance Director stated when the side rails were ordered for a resident, he then conducted a bed/side rail inspection, which included obtaining measurements to identify the potential areas of entrapment, within the seven zones. The Maintenance Director stated the measurements obtained from each zone were documented on the facility's Bed System Measurement Device Test Results Worksheet. Review of Resident 83's Bed System Measurement Device Test Results Worksheet dated 8/3/24, failed to show the measurements for Zones 1, 6, and 7. The Maintenance Director verified the findings. On 10/9/24 at 1647 hours, the Administrator and DON were informed and acknowledged the above findings. 48882 (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 80's medical record showed a facility document titled Bed System Measurement Device Test Results Worksheet, undated, for the use of bilateral half side rails for bed mobility. However, further review of the facility document failed to show evidence the side rail entrapment assessment was completed and documented. On 10/7/24 at 0941 hours, an interview was conducted with Resident 80. Resident 80 stated she used the bed side rails to grab onto during care and for repositioning in bed. On 10/8/24 at 1220 hours, an interview was conducted with CNA 9. CNA 9 stated Resident 80 used the side rails during incontinent care for assistance with turning. On 10/10/24 at 1056 hours, an interview and concurrent medical record review for Resident 80 was conducted with the DON. The DON verified the above findings. 14. On 10/7/24 at 0916 hours, and 10/9/24 at 0746 hours, Resident 87 was observed in bed with bilateral half side rails elevated. Medical record review for Resident 87 was initiated on 10/7/24. Resident 87 was admitted to the facility on [DATE]. Review of Resident 87's H&P examination dated 9/11/24, showed Resident 87 had the capacity to understand and make decisions. Review of Resident 87's Order Summary Report dated 10/9/24, showed a physician's order dated 9/10/24, for the use of bilateral half side rails for bed mobility and enabler use. Review of Resident 87's plan of care showed a care plan problem initiated on 9/10/24, addressing Resident 87's use of side rails and risk for entrapment. The interventions showed to check for proper positioning while in bed for the risk of entrapment every shift, and to provide visual checks of the bed, mattress, and rail for appropriateness of the resident's dimensions. Review of Resident 87's facility document titled Bed System Measurement Device Test Results Worksheet dated 9/10/24, for the use of bilateral half side rails showed only zones 2, 3, and 4 were assessed for entrapment and documented as P for pass. The document failed to show Zones 1, 6, and 7 were assessed for entrapment. On 10/8/24 at 1225 hours, an interview was conducted with CNA 9. CNA 9 stated Resident 87 used the side rails during the incontinent care and during wound treatments. On 10/9/24 at 1035 hours, an interview and concurrent medical record review for Resident 87 was conducted with LVN 7. LVN 7 verified the above findings. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/9/24 at 0941 hours, an interview and concurrent facility document review was conducted with the Maintenance Director. The Maintenance Director stated he checked the beds quarterly and when the nursing staff informed him of new residents with side rail orders. Upon notification of a new side rail order, the Maintenance Director stated he would be responsible for installing the side rails onto the resident's bed and conducting the entrapment assessment. The Maintenance Director stated he documented the entrapment assessment on the facility document titled, Bed System Measurement Device Test Results Worksheet and he kept the forms in his binder. Concurrent document review was conducted with the Maintenance Director. The Maintenance Director verified the facility's entrapment assessment only assessed for entrapment for Zones 2, 3, and 4. The Maintenance Director verified no other zones were listed on the entrapment assessment. Further review of the Maintenance Director's binder failed to show documentation of the entrapment assessment for Residents 77, 80, or 87. On 10/10/24 at 1030 hours, during a follow-up interview with the Maintenance Director. The Maintenance Director stated he could not find the entrapment assessments for Residents 77 and 80. The Maintenance Director also verified Resident 87's Bed System Measurement Device Test Results Worksheet dated 9/10/24, only assessed for Zones 2, 3, and 4. The Maintenance Director further stated entrapment assessment for Zones 1, 6, and 7 were not documented. On 10/10/24 at 1556 hours, the Administrator, DON, and Medical Records Assistant were informed and acknowledged the above findings. 37726 15. Medical record review for Resident 49 was initiated on 10/7/24. Resident 49 was admitted to the facility on [DATE]. Review of Resident 49's Order Summary Report showed an order dated 1/15/24, for the bilateral side rails for bed mobility and for use as an enabler. On 10/7/24 at 0830 hours, an observation and concurrent interview was conducted with Resident 49. Resident 49 was observed lying in bed with the bilateral side rails elevated. Resident 49 stated he utilized the side rails to repositioning himself in bed. On 10/10/24 at 1305 hours, an interview and concurrent record review was conducted with the Maintenance Director. The Maintenance Director stated when the side rails were ordered for a resident, he then conducted a bed/side rail inspection, which included obtaining measurements to identify potential areas of entrapment, within seven zones. The Maintenance Director stated the measurements obtained from each zone were documented on the facility's Bed System Measurement Device Test Results Worksheet. Review of Resident 49's Bed System Measurement Device Test Results Worksheet dated 1/15/24, failed to show the measurements for Zone 1, 6, and 7. The Maintenance Director verified the findings.