STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555557	A. Building B. Wing	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pioneers Memorial Skilled Nursing Center	320 Cattle Call Dr. Brawley, CA 92227

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 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** 39220 Based on interview and record review, the facility was unaware of an Advanced Directive (a legal document which lists preferences for life-saving measures) related to a resident wishes for resuscitative efforts (life-saving measures) for one of three residents (Resident 36), reviewed for Advanced Directives. As a result, there was the potential Resident 36's wishes for resuscitative efforts would not be honored. Findings: Resident 36 was admitted to the facility on [DATE], with diagnoses of Parkinson's disease (a progressive neurological disease), per the facility's Admission Record. On [DATE], Resident 36's clinical record was reviewed. According to the physician's order dated [DATE], CPR (cardio-pulmonary resuscitation, a life-saving measure) was listed, indicating if Resident 36 were to go into cardiac arrest (when the heart stops beating), the staff were to perform full resuscitation measures. There was no documented evidence a Physician's Order for Life Sustaining Treatment (POLST) was in the clinical record. According to Resident 36's electronic record, an Advanced Directive, signed and dated [DATE], had been scanned into the Documents section of the electronic record on [DATE]. The Advanced Directive indicated, Do not resuscitate, no life supporting measures. According to the facility's most recent Multidisciplinary Care Conference (a quarterly meeting when all department heads meet to discuss the resident's care and to identify potential issues), dated [DATE], . Section 9. Resident/Family. Care level reviewed: boxes labeled DNH (do not hospitalize), DNR (Do not resuscitate), Undecided, and Full resuscitation were blank and unmarked . (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1:16 P.M., and observation and interview was conducted of Resident 36 in the physical therapy department. Resident 36 was dressed, standing and doing independent arm exercises. Resident 36 was asked what her resuscitative wishes were. Resident 36 stated they asked her that in the hospital and she told them she did not want CPR (cardiopulmonary resuscitation) performed on her. Resident 36 stated, I just want them to make me comfortable and to let me go. Resident 36 stated no one at the facility had asked her what her wishes were. On [DATE] at 8:38 A.M., an interview and record review was conducted with the ADON. The ADON stated if there was no POLST in the paper chart, the staff would check the physician's order and do what was listed in the physician's order. The ADON stated if there was no POLST or physician's order, staff would automatically perform CPR. The ADON was unaware an Advanced Directive had been scanned into Resident 36's electronic chart, listing the Resident's wishes as, Do Not Resuscitate. The ADON stated by missing the resident's Advanced Directive, there was the potential for Resident 36's wishes to not be followed and it could also be a legal issue. The ADON stated this should have been captured and communicated and it was not. The ADON stated it was also missed during their quarterly Multidisciplinary Care Conference. On [DATE] at 8:34 A.M., an interview was conducted with the DON. The DON stated she expected all resident wishes for Advanced Directive and POLST to be recognized and honored. According to the facility's policy, titled Advanced Directive, dated [DATE], .The Facility will respect a resident's Advanced Directive and will comply with the resident's wishes expressed in an advanced directive. According to the facility's policy, titled Physician Orders for Life-Sustaining Treatment (POLST), dated [DATE], .VII. Whenever possible, ensure that the Advanced Directive and the POLST form are consistent .V . C. If the resident has an Advanced Healthcare Directive, copies of it may be attached to the current original POLST in the front of the 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. 39220 Based on observation, interview and record review, the facility failed to provide a safe, homelike environment when: 1. An exterior resident room door for one of 25 rooms (room A) had peeling paint, and 2. An exterior shower room door frame for one of two shower rooms (Station B), had holes and exposed drywall, along with two protruding nails. As a result, there was the potential for residents to experience diminished self-worth and the possibility of injury from the environment hazards (peeling paint and protruding nails). Findings: 1. On 4/9/24 at 8:24 A.M., an observation was conducted of room A's exterior door leading to the hallway. Room A housed four residents, two of whom were cognitively impaired (Residents 49 and 154) The exterior door had missing and peeling white paint, with an estimated size of 14 inches horizontally and nine inches vertically. On 4/9/24 at 8:56 A.M., an observation and interview was conducted with the Director of Maintenance (DM) of room A's exterior door. The DM stated he received work requests daily from staff, requesting repairs. The DM stated he repaired things as the requests were submitted by staff. The DM stated he did not keep a maintenance log of future repairs needed, stating he fixed things as they were identified and requested. The DM stated he did not have a work request for the exterior room door (Room A), and stated he was unaware the paint was peeling. The DM viewed room A's door and stated, It does not look good and needs repair. On 4/9/24 at 9:05 A.M. an observation and interview was conducted with the Administration (ADM) of room A's exterior door. The ADM stated the paint on the door was peeling and confused residents could grab and ingest the paint chips. The ADM stated the door looked bad and should be fixed. 2. On 4/9/24 at 8:27 A.M., an observation was conducted of the exterior shower room wall in Station B. Multiple holes and gaps were present on both sides of the wall next to the door frame. Two nails were observed protruding on the right side of the exterior door frame. One nail was approximately six feet above the floor and the second nail was approximately three feet above the floor. On 4/9/24 at 8:59 A.M., an observation and interview was conducted with the Director of Maintenance (DM) of Station B's exterior shower door frame. The DM stated new shower door frames had been installed by an outside company in approximately September 2023. The DM stated the outside company was supposed to return to the facility to repair the walls, but they had not. The DM stated he had not called the outside company to inquire when they would be back to fix the walls. The DM stated the walls around the new shower door frame looked bad, with the exposed holes and drywall. The DM removed the nail at the six-foot level with his pliers, and stated he would remove the second lower nail as well. The DM stated the protruding nails could have placed residents at risk of being injured . (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/9/24 at 9:06 A.M., an observation and interview of Station B's exterior shower door frame was conducted with the ADM. The ADM stated the shower wall looked bad and did not present a homelike environment to the residents. The ADM stated residents and staff could have been injured if they came into contact with the protruding nails. The facility provided an undated policy, titled Resident Rooms and Environment, which indicated, .1. Facility staff aim to create a personalized, homelike atmosphere, paying close attention to the following: A. Cleanliness and order; .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on interview and record review, the facility failed to capture and transmit accurate MDS (a clinical assessment tool) information to the Centers for Medicare and Medicaid Services (CMS-a Federal agency), for two of five residents (Resident 3 and Resident 36) reviewed for Resident Assessment. This failure had the potential to affect the care and services provided to Resident 3 and Resident 36. Findings: 1. Resident 3 was readmitted to the facility on [DATE], with diagnoses which include dementia (progressive memory loss) and schizoaffective disorder, (a mental disorder marked by schizophrenia symptoms such as hallucinations and delusions), per the facility's Admission Records. On [DATE], Resident 3's clinical record was reviewed. The Admission MDS, dated [DATE], Section I, did not identify the diagnosis of, Schizophrenia: (i.e. schizoaffective and schizophreniform disorder). On [DATE] at 9:35 A.M., an interview and record review was conducted with MDSN 2. MDSN 2 stated on admission, the MDSN would review the resident's history & physical, physician orders, nurses notes, and the admission assessment to gather information for MDS coding. The MDSN reviewed Resident 3's admitting diagnoses and the triggered active diagnoses in the Admission MDS, dated [DATE]. The MDSN stated there was a diagnosis of schizophrenia on the Admission Record and it was not listed on the MDS as an active diagnosis. The MDSN stated since the MDS diagnoses was not correct when transmitted, CMS did not have the correct information on Resident 3's current health status and I missed it. The MDSN continued, stated it was important for CMS to know the admitting diagnoses and status of each resident, so they were aware of the current care being provided. 2. Resident 36 was admitted to the facility on [DATE], with a diagnosis of Parkinson's disease (a progressive neurological disease), per the facility's Admission Record. On [DATE], Resident 36's clinical record was reviewed. According to the physician's order dated [DATE], CPR (cardio-pulmonary resuscitation) was listed, indicating if Resident 36 were to go into cardiac arrest (when heart stops beating), the staff were to perform full resuscitation (life-saving) measures. According to Resident 36's electronic record, an Advanced Directive, (a legal document listing the resident's wishes for life supporting measures), dated [DATE], was scanned into the Documents electronic section on [DATE], indicating, Do not resuscitate, no life supporting measures. According to the quarterly MDS, dated [DATE], titled Advanced Directive, no choices for life-sustaining treatment was completed. All sections were left blank. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 9:06 A.M., an interview and record review was conducted with MDSN 1. The MDSN 1 stated she routinely checked the resident's records and physician orders when submitting Physician's Orders for life Sustaining Treatment (POLST) and Advanced Directive information to CMS. The MDSN 1 reviewed Resident 36's admission MDS, dated [DATE], and the last quarterly MDS dated [DATE]. The MDSN 1 stated the admission and the quarterly MDS was not completed for Section S, titled California POLST/Advanced Directive. The MDSN 1 reviewed Resident 36's electronic record for an Advanced Directive, stating it was scanned in on [DATE], and she was never informed. The MDSN 1 stated as a result, the POLST and Advanced Directive were not captured. The MDSN 1 stated because it was not captured, CMS and the facility was unaware of what the resident's resuscitative wishes were. On [DATE] at 8:34 A.M., an interview was conducted with the DON. The DON stated she expected an accurate assessment of all residents, because the facility and CMS needed to be aware of the residents wishes for resuscitative efforts. According to the MDS 3.0 Resident Assessment Instrument [NAME], dated [DATE], Resident Assessment Protocols (RAPs) are reviewed following the completion of the MDS portion of the RAI (Resident Assessment Instrument) for comprehensive assessments in order to identify the resident's strengths, problems, and needs. This decision-making process is documented on the Resident Assessment Protocol Summary .The comprehensive RAI is considered complete on the date the RN (registered nurse) Coordinator indicates completion of the RAPs .The quarterly assessment is used to track the resident's status between comprehensive assessments, and to ensure monitoring of critical indicators of the gradual onset of significant changes in resident status .

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on interview and record review, the facility failed to ensure a Pre-admission Screening and Resident Review Level 2 (PASARR- a Federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) was completed after a new diagnoses of schizophrenia was made for one of one resident (Resident 3) reviewed for PASARR. As a result, there was potential for Resident 3 to be improperly placed at the facility where necessary services were not available. Findings: 1. Resident 3 was readmitted to the facility on [DATE] with diagnoses which included dementia (progressive memory loss) and schizoaffective disorder, (a mental disorder that is marked by schizophrenia symptoms such as hallucinations and delusions), per the facility's Admission Records. On 2/13/24, Resident 3's clinical record was reviewed. The Admission MDS, dated [DATE], Section I, did not include the diagnoses of Schizophrenia (i.e. schizoaffective and schizophreniform disorder). The original PASARR Level 1 was completed as Negative on 9/14/20. On 2/14/24 at 9:35 A.M., an interview and record review was conducted with MDSN 2. MDSN 2 stated on admission, she reviewed the resident's history & physical, physician orders, nurse's notes, and the admission assessment to gather information for MDS coding. The MDSN reviewed Resident 3's admitting diagnoses and the triggered active diagnoses listed in the Admission MDS. The MDSN stated there was a diagnosis of schizophrenia on the Admission Record and it was not listed on the MDS as an active diagnosis. The MDSN stated since the MDS diagnoses were not correct when transmitted, CMS did not have the correct information on Resident 3's current health status and stated, I missed it. The MDSN 2 continued, stated the original PASARR Level 1 was completed at the hospital, and once she came to their facility, she was later diagnosed with Schizophrenia. The MDSN 2 stated on the re-admission, it should have triggered another PASARR to be completed which would have triggered as, Positive, since she had the diagnoses of schizophrenia. The MDSN 2 stated when a PASARR Level 1 was positive, the State was notified, and someone would come within days to assess the resident. The MDSN 2 stated the assessment was to ensure the resident was appropriate for this setting and to provide outside services to enrich her quality of life, such as classes. The MDSN 2 stated since she missed the diagnoses of schizophrenia, it did not prompt her to complete an additional PASARR Level One, which was mandated. The MDSN 2 stated because this was completely missed, The Centers for Medicare and Medicaid Services (CMS, a Federal agency) and the State were unaware of the current care provided and unable to determine if this was appropriate for her diagnoses. On 2/15/24 at 8:34 A.M., an interview was conducted with the DON. The DON stated MDS assessments needed to be accurate on admission to ensure the residents were getting the care and services they required. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/27/24 at 12:46 P.M., the Admin emailed a copy of Resident 3's PASARR Level 1, completed on 10/12/22, listing a Positive screening for, Suspected Mental Illness. The Admin could not provide any documented proof a PASARR Level 2 was completed by the State, or that the facility followed up with the State to ensure a PASARR Level 2 was completed in a timely manner. According to the facility's policy, titled Pre-Admission Screening Resident Review (PASARR), dated January 2012, .1V. Level 1 screening for Residents who experience a significant change in condition: A. If any facility resident experiences a significant change in condition in health status that raises the possibility of a change in the residents MI/MR [mental illness/mental retardation], status or physical status, the Facility must compete a new PASARR 1 Screening Document. B. If the Level I screening indicates the need for a Level 2 screening, contact the appropriate State agency for a Level 2 determination .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38512 Based on observation, interview and record review, the facility failed to develop and implement individualized care plans for three of 18 residents sampled (Residents 14, 51, 7). These failures had the potential for the residents to not receive the care and services needed to preserve optimal health status and prevent further decline. 47466 Findings: 1) A review of Resident 14's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnosis which included End Stage Renal Disease (kidney failure) and Dependence on Renal Dialysis (a process to filter the blood of toxins). An interview and observation with Resident 14 was conducted on 2/12/24 at 12:29 P.M. Resident 14 stated he went to dialysis three times a week. A shunt (access site for dialysis) on his right upper arm was observed. A joint interview and record review on 2/14/24 at 4:39 P.M., was conducted with LN 31. LN 31 stated there was no care plan for dialysis. LN 31 stated it was important for a dialysis care plan to have been developed and implemented, as it could affect Resident 14's care. An interview and record review was conducted on 2/15/24 at 7:40 A.M., with LN 35. LN 35 stated a care plan had not been developed for dialysis for Resident 14. LN 35 stated a care plan directed and guided the healthcare staff to provide dialysis care of Resident 14. A joint interview and record review was conducted on 2/20/24 at 3:50 P.M., with the DON. The DON indicated there was no active dialysis care plan in Resident 14's medical record. The DON stated it was important for a care plan to be developed so the healthcare staff knew what specific care and treatment Resident 14 required for dialysis treatment. 2) A review of Resident 51's Admission Record indicated Resident 51 was admitted to the facility on [DATE] with diagnosis that included Diabetes Mellitus (abnormal blood sugar levels). A joint interview and record review on 2/14/24 at 4:50 P.M., was conducted with LN 31. LN 31 stated Resident 51's care plan on diabetes did not contain resident-specific interventions including monitoring for abnormal blood sugar levels. An interview and record review was conducted on 2/15/24 at 9:37 A.M., with the ADON. The ADON stated Residents 51's care plan was not individualized and did not include monitoring for abnormal blood sugar levels. 48263 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. A review of Resident 7's Admission Record indicated the resident was admitted in the facility on 4/1/23 with diagnoses to include dementia (a condition that affects a person's memory, thinking and ability to perform everyday activities) and left humerus (upper arm bone) fracture. A record review of Resident 7's MDS (an assessment tool) dated 12/26/23, indicated Resident 7's cognitive skills to make daily decisions was moderately impaired (decisions poor; cues/supervision required). On 2/15/24 at 10:48 A.M., an interview with CNA 22 was conducted. CNA 22 stated Resident 7 yelled when she wanted something, such as repositioning for comfort. On 2/15/24 at 10:55 A.M., an interview and record review was conducted with LN 22. LN 22 stated Resident 7 complained about pain during transfers, showers, and during exercises. LN 22 was unable to locate a care plan related to pain. On 2/15/24 at 2:15 P.M., an observation of Resident 7 was conducted. Resident 7 was yelling out and could be heard from the hallway. A joint interview and record review of Resident 7 was conducted on 2/20/24 at 8:24 A.M., with MDSN 1 (nurses who specialized in assessing the needs of long-term care residents). MDSN 1 stated there was no pain care plan developed for Resident 7. MDSN 1 stated that she did not know Resident 7 complained of pain during transfers and movement of upper and lower extremities (refers to arms and legs) and should be addressed as part of Resident 7's care plan for pain. An interview with the DON was conducted on 2/20/24 at 9:15 A.M. The DON stated Resident 7's care plan for pain should have been developed to address Resident 7's pain triggers. The DON acknowledged pain indicators such as body language, facial expressions and mood should have been included in a person-centered care plan to identify Resident 7's pain and discomfort. The DON stated a care plan for pain had not been developed. A review of the facility's policy, revised November 2018 and titled Comprehensive Person-Centered Care Planning, indicated, Purpose .to ensure that a comprehensive person-centered care plan is developed for each resident. Procedure 1 a it should address resident- specific health and safety concerns to prevent injury, identify needs for supervision, and assistance with activities of daily living, as necessary .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38512 Based on observation, interview and record review, the facility failed to update and revise individualized care plans for two of 18 residents sampled (Residents 19, 21). These failures had the potential for the residents to not receive the care and services needed to preserve optimal health status and prevent further decline. Findings: 1. Resident 19 was admitted to the facility on [DATE] with diagnoses to include dementia (a loss of memory, language, problem-solving and other thinking abilities that interfere with daily life), per a facility Admission Record. On 2/12/24 at 11:46 A.M., Resident 19 was observed in his room, in bed. Resident 19's mattress had bolsters on each side, approximately four inches high, four inches wide, and 36 long. The bolsters were attached to the mattress, and were covered with a fitted sheet. In addition, fall mats were on the floor on either side of the bed. Resident 19 indicated, using gestures, that the bolsters were to prevent him from falling. On 2/12/24 at 11:55 A.M., an interview was conducted with LN 1. LN 1 stated she was not sure what the bolsters were for, but she was aware Resident 19 had fallen in the past and she thought the bolsters were placed to prevent the resident from falling out of bed. LN 1 stated the care plan would be her resource for information on the bolsters. On 2/20/24 a record review was conducted. Resident 19's MDS (an assessment tool), dated 1/1/24, listed a cognitive score of 3, indicating severely impaired cognition. The MDS indicated he had fallen two times or more since admission, with no injury sustained. Resident 19's care plan, initiated 9/21/23, indicated Resident 19 was at high risk for falls. The care plan did not include the bolsters. On 2/20/24 at 4 P.M., a concurrent interview and record review was conducted with the ADON. Per the ADON, the care plan did not include the bolsters. The ADON stated staff should be aware of Resident 19s fall history. The ADON stated the care plan should have been updated to include the use of the bolsters so staff had a clear understanding of the plan to protect the resident. Per the ADON, The bolsters are for safety, but it should be care planned. 2. Resident 21 was admitted to the facility on [DATE] with diagnoses to include dementia (the loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life) and protein-calorie malnutrition (a type of undernutrition that occurs when not enough protein and calories were eaten), per the facility's Admission Record. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/24 at 12:40 P.M., an observation of Resident 21 was conducted during lunch. Resident 21 had consumed less than half of the foods provided on the tray. Resident 21 was wheeling away from the tray, and indicated he did not want more food by waving his hand at it as he wheeled away. On 2/13/24 at 8:32 A.M., an observation of Resident 21 was conducted during breakfast. Resident 21 had eaten less than half of the foods provided on his breakfast tray. Resident 21 stated he was finished and did not want more food. On 2/20/24, a record review was conducted. On 11/29/23, Resident 21s MDS (an assessment tool), listed cognitive score was 12, indicating moderately impaired. The nutrition section indicated Resident 21 had weight loss of 5% or greater of his body weight in the last month, a loss of 10% or greater of his body weight in the last six months, and was not on a prescribed weight loss regimen. On 7/30/23, a care plan for weight loss was initiated. Multiple goals were established, including the resident was to consume >75% of his meals, supplements and snacks. The interventions were to, see RD recommendation 7/28. On 2/20/24 at 11:55 A.M., a telephone interview was conducted with the RD. The RD stated she was familiar with Resident 21. Per the RD, care plans could be implemented by either the RD or the nurse. The RD stated care plans were very important, as they gave a summary of important nutrition interventions for each resident. The RD stated it was not appropriate to reference a Nutrition progress note rather than document the interventions on the care plan. Per the RD, the lack of a care plan could result in further weight loss. On 2/20/24 at 12:26 P.M., a concurrent interview and record review was conducted with the ADON. The ADON reviewed the nutrition care plan and stated interventions should have been revised with specific interventions, rather than referencing the RD note. Per the ADON, the care plan was important to communicate issues that were interdisciplinary, such as weight loss and diet changes. The ADON stated the current nutrition care plans needed to reflect the current nutrition goals for Resident 21, but did not. Per a facility policy, revised November 2018 and titled Comprehensive Person-Centered Care Planning, Purpose: To ensure that a comprehensive person centered care plan is developed for each resident .I. c. The baseline care plan must .include interventions that address his or her needs .IV. a .All goals, objectives, interventions, etc. from the current baseline care plan will be included in the resident's comprehensive care plan. b. Additional changes or updates to the resident's comprehensive care plan will be made based on the assessed needs of the resident .

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Pioneers Memorial Skilled Nursing Center	320 Cattle Call Dr. Brawley, CA 92227

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on observation, interview and record review, the facility failed to provide care and services to maintain the highest quality of life, when haircuts were not provided for one of two resident (Resident 42) reviewed for Activities of Daily Living (ADL-basic daily care such as showers, grooming, dressing, nail care, and personal hygiene). The facility failed to ensure a system was in place to address the haircut needs for all 83 residents in the facility, when haircutting services were not offered or provided by the facility from April 1, 2023 through February 14, 2024 (a 10-month period). As a result, all residents had the potential for diminished dignity and self-esteem. Findings: A review of Resident 42's admission record was conducted. Resident 42 was readmitted to the facility on [DATE], with diagnoses which included dementia (progressive memory loss). On 2/12/24 at 9:36 A.M., an observation was conducted of Resident 42, during initial tour. Resident 42 was sitting in a wheelchair in the physical therapy room. Resident 42's hair was past hanging down on the sides, below his ears, and the back of the hair was long, past his neck. On 2/12/24 at 3:42 P.M., a telephone family interview was conducted with Resident 42 daughter. The daughter was informed of Resident 42's long hair and the family member was asked if Resident 42 would want his haircut. Resident 42's daughter stated, My father always likes to keep his hair very short and trimmed, so yes, he would want to have his haircut. On 2/13/24, Resident 42's clinical record was review: The facility's Admission Record had a picture of the Resident 42 with short hair, located in the upper left corner of the with Admission Record. The quarterly Minimum Data Set (MDS-a clinical assessment tool), dated 1/13/24, listed a cognitive score of 3, indicating cognition was severely impaired. The functional abilities section indicated Resident 42 required supervision and assistance with personal hygiene, such as combing hair, shaving, washing hands. On 2/14/24 at 7:37 A.M., an interview was conducted with Resident 42, with the assistance of the Medical Record Director (MRD), for Spanish interpretation. Resident 42 was dressed, sitting in a wheelchair in his room. When asked if he wanted a haircut, Resident 42 answered, yes. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/14/24 at 9:52 A.M., an interview was conducted with the Activity Director (AD). The AD stated she was responsible for coordinating and scheduling haircut appointments for all the residents. The AD stated they had been looking for a certified barber/beautician since their facility had a change of ownership (transfer of ownership from one entity to another), in April 2023, and was taken over by the hospital. The AD stated the last time a barber or beautician was in the facility to cut residents' hair was in March 2023, before the change of ownership. The AD continued, stating the hospital (new owner) informed the facility, the hospital wanted to vet, (the process of thoroughly investigating an individual, company before deciding to move forward) a new barber or beautician, before hiring someone to cut resident hair. The AD was asked how the facility was supplying haircuts, while waiting for the vetting to occur. The AD stated they did not have anyone to cut hair, so some family members were bringing in their own hairdressers, to cut their loved one's hair. The AD stated the hairdressers coming in, would bring their own supplies and the haircut would occur outside the facility's in their courtyard. The AD stated residents without any family members to help, had not been getting their haircut. The AD stated since the building was taken over as a D/P (Distinct Part: a hospital-based facility usually operated in a designated unit within a hospital), in April 2023, no haircuts have been provided. The AD stated she called the hospital in May, August, October, and December 2023, to inquire with how the hiring process was going and was told by the hospital, they were still working on it. The AD stated she was frustrated with the delay and the negative impact it could have on all the residents, because it was a dignity and self-esteem issue. The AD stated the residents and their families were not supposed to provide their own haircuts by outside sources, because it was the facility's responsibility and duty to provide that duty. The AD stated she was aware Resident 42 preferred his hair short and his family had also told her that in the past. On 2/15/24 at 8:30 A.M., an interview was conducted with the DON. The DON stated, I could not tell you when the last time someone was in the building to cut the residents' hair. The DON stated she was aware it was an issue and resident haircuts had not been performed for a long time. The DON stated the AD routinely was trying to get the hospital to finish their contract process, so someone could be hired, because the residents needed their haircuts. The DON stated not having someone to groom and cut hair, could affect a resident's self-esteem and dignity, because their ADL needs were not being met. On 2/15/24 a record viewed was conducted of the facility's policy, titled Resident Rights-Quality of Life, dated March 2017, Each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect, individuality and received services in a person-centered manner .1. Resident are groomed as they wish . On 2/15/24 an additional record review was conducted of the facility's policy, titled Resident Rights-Accommodation of Needs, dated January 2012, .1. Residents' individual needs and preferences are accommodated to the extent possible . On 2/15/25 an interview was conducted with the Medical Records Director (MRD). The MDR stated she unable to locate facility policies related to Haircuts or Activities of Daily Living.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47466 Based on interview and record review, the facility failed to provide the necessary care and treatment for one of five residents (Resident 51) reviewed for diabetes (a chronic [long lasting] health condition that affects how your body turns food into energy) care when: Resident 51's physician was not notified of the resident's hypoglycemic (low blood sugar) episodes. Resident 51's blood sugar was not monitored in accordance with the standard of practice (scope and authority related to a specific activity by defining who can do what activity, with what level of supervision and when) for residents with diabetes. Resident 51 received multiple oral diabetic medications. As a result, Resident 51's became unresponsive and was sent to the hospital on 1/31/24. Resident 51 was diagnosed with sulfonylurea (medication use for the treatment of non-insulin dependent diabetes mellitus [DM - a condition in which the body has trouble controlling blood sugar] which can cause significant hypoglycemia [low blood sugar] after the ingestion of one or two pills), polypharmacy (simultaneous use of multiple drugs for the same ailment or condition) and urinary tract infection (an infection in the urinary system). Findings: A record review of Resident 51's undated Admission Record indicated that Resident 51 was admitted to the facility on [DATE] with a diagnosis that included diabetes mellitus. A review of Resident 51's minimum data set (MDS- an assessment tool), dated 1/17/24 indicated a BIMS (brief interview for mental status - a tool to screen and identify the cognitive condition of residents) score of 1. 0 which indicated severe cognitive impairment. A record review of Resident 51's physician orders, dated January 2024 indicated the following: Glimepiride (a diabetic medication) 4 milligrams (mg), 1 tablet by mouth daily for DM ordered on 1/10/24 at 10:14 P.M. Insulin glargine (a diabetic medication) inject 10 units subcutaneous (under the skin) at bedtime for DM ordered on 1/10/24 at 10:14 P.M. Sitagliptin (a diabetic medication) 50 mg 1 tablet by mouth daily for DM ordered on 1/10/24 at 10:14 P.M. Pioglitazone (a diabetic medication) 50 mg, 1 tablet by mouth daily for DM ordered on 1/10/24 at 10:14 P.M. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	An interview on 2/15/24 at 7:25 A.M., with licensed nurse (LN) LN 35 was conducted. LN 35 stated Resident 51's blood sugar needed to be monitored at least twice a day or more frequently due to the resident's history of low blood sugar. A record review of Resident 51's hospital history and physical, written by a physician, dated 2/8/24, indicated, I believe that polypharmacy is playing a significant role in the patient becoming hypoglycemic. Per the same history and physical, Resident 51 was diagnosed with sulfonylurea induced hypoglycemia (severe low blood sugar) and urinary tract infection. An interview with Resident 51's medical doctor (MD) 1 was conducted on 2/15/24 at 7:45 A.M. MD 1 stated the use of multiple diabetic medications without monitoring the resident's blood sugar could lead to hypoglycemia. MD 1 stated that residents diagnosed with DM should have their blood sugar monitored more than twice daily. MD 1 stated the nurses should have notified him of Resident 51's low blood sugar. On 2/15/24 at 7:52 AM., an interview with LN 31 was conducted. LN 31 stated Resident 51 was sent out to the hospital early this morning for a low blood sugar. LN 31 stated Resident 51 will be returning to the facility today (2/15/24), as reported by the hospital emergency room (ER) nurse. LN 31 stated according to the ER nurse, the ER physician recommended to stop all of Resident 51's diabetic oral medications until reviewed by Resident 51's physician. An interview with the Pharmacy Consultant (PC) was conducted on 2/15/24 at 8:06 A.M. The PC stated that Resident 51's blood sugar should have been checked twice daily or more since Resident 51 was on multiple diabetic medications. An interview and joint record review of Resident 51's January 2024 medication administration record (MAR)and progress notes was conducted with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 2/20/24 at 2:21 P.M. Resident 51's MAR indicated the following blood sugar results: On 1/11/2024 at 9:00 P.M., blood sugar was 56. On 1/20/2024 at 9:00 P.M., blood sugar was 60. On 1/21/2024 at 9:00 P.M., blood sugar was 65. On 1/22/2024 at 9:00 P.M., blood sugar was blank On 1/24/2024 at 9:00 P.M., blood sugar was blank. On 1/29/2024 at 9:00 P.M., blood sugar was 41. On 1/30/2024 at 9:00 P. M.,blood sugar was 48. On 1/31/2024 at 9:00 P.M., blood sugar was 43. Resident 51's nursing progress notes indicated the following: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 1/11/24 at 9:51 P.M., Resident 51's blood sugar was 56. The nurse initiated the facility's hypoglycemia protocol (interventions to reverse low blood sugar). The DON stated there was no documented evidence that Resident 51's M.D., was notified regarding the resident's low blood sugar result. The DON stated there was no documented evidence that Resident 51's blood sugar was reassessed. On 1/20/24 at 8:10 P.M., Resident 51's blood sugar was 60. The nurse initiated the facility's hypoglycemia protocol. The DON stated there was no documented evidence that Resident 51's M.D., was notified regarding the resident's low blood sugar result. The DON stated there was no documented evidence that Resident 51's blood sugar was reassessed. On 1/21/24 at 8:45 P.M., Resident 51's blood sugar was 65. The nurse initiated the facility's hypoglycemia protocol. The DON stated there was no documented evidence that Resident 51's M.D., was notified regarding the resident's low blood sugar result. The DON stated there was no documented evidence that Resident 51's blood sugar was reassessed. On 1/22/24 at 10 P.M., the DON stated Resident 51's blood sugar result was not documented on the MAR. According to the progress notes, Insulin glargine 10 units at bedtime held d/t (due to) BS (blood sugar) results outside of normal of BS parameter less than 60. The DON stated there was no documented evidence that Resident 51's M.D., was notified regarding the resident's low blood sugar result. The DON stated there was no documented evidence that Resident 51's blood sugar was reassessed. On 1/24/24 at 9 P.M., the DON stated Resident 51's blood sugar was not documented on the MAR and progress notes. On 1/29/24 at 9:48 P.M., Resident 51's blood sugar was 41. The DON stated there was no documented evidence that Resident 51's MD was notified regarding the resident's low blood sugar. The DON stated there was no documented evidence that Resident 51's blood sugar was reassessed. On 1/30/24 at 9:44 P.M., Resident 51's blood sugar was 48. The DON stated there was no documented evidence that Resident 51's MD was notified regarding the resident's low blood sugar. The DON stated there was no documented evidence that Resident 51's blood sugar was reassessed. On 1/31/24 at 5:29 P.M., Resident 51's son came to the facility and found Resident 51 unresponsive. Resident 51's blood sugar result was 43. The nurse called 911 and transferred Resident 51 to the hospital. An interview with LN 34 was conducted on 2/20/24 at 11:24 A.M., LN 34 stated that Resident 51's MD should have been notified of Resident 51's low blood sugars and documented in the progress notes. LN 34 stated if the care was not documented, then the care was not done. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	An interview and joint record review was conducted with the DON and ADON on 2/20/24 at 2:21 P.M. The DON stated when caring for a resident experiencing a hypoglycemia episode, the nurses should monitor the residents blood sugar, conduct a pre and post assessment of the residents condition, follow the facility's hypoglycemia protocol (give half (1/2) cup of orange juice , 1/2 cup of soft drinks, 1 cup of milk, 1/2 cup of apple juice, or other item with 15-30 grams of carbohydrates- calories and to continue offering the resident carbohydrates until blood sugar is above 70), notify MD and document the incident in the resident's medical record. The DON stated all the above were important to ensure that the resident care needs were addressed. The ADON stated she should have communicated Resident 51's multiple diabetic medications when the resident was first admitted to the facility. The ADON stated medication review should have been done due to Resident 51's multiple diabetic medications to avoid hypoglycemia episodes. A review of the facility's undated policy and procedure titled, Hypoglycemia was conducted. The policy indicated, Procedure . II- Treatment of hypoglycemia . B. Severe Hypoglycemia I. Notify the attending physician immediately . VI. Monitor resident closely, checking fingerstick and vitals every 15 minutes until stable or transferred. VII. document all interventions as ordered and implemented .

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on observation, interview, and record review, the facility failed to prevent a further decline of a pressure ulcer (skin damaged by lack of movement due to staying in a position for too long), for one of six residents (Resident 35) reviewed for pressure ulcer. As a result, Resident 35's sacral (tailbone) pressure ulcer worsened from a stage II (shallow wound like a blister or abrasion) to a stage III (full thickness tissue injury; open wound that goes deeper into the tissue beneath). Findings: A review of Resident 35's Admission Record indicated Resident 35 was admitted to the facility on [DATE] with diagnoses which included a history of hemiplegia (total paralysis of one side of the body), hemiparesis (refers to partial paralysis, indicating weakness rather than complete loss of movement), cerebral infarction (stroke), and diabetes mellitus (high blood sugar). A record review of Resident 35's Minimum Data Set (MDS- assessment tool) dated 12/31/23, indicated Resident 35's Brief Interview for Mental Status (BIMS- zero to seven [0-7] suggested severe cognitive [thinking process] impairment) was zero. In addition, the MDS indicated that Resident 35 was at risk for developing pressure ulcers and was dependent on staff for bed mobility. A review of Resident 35's care plan was conducted. There was no care plan developed related to Resident 35's stage II pressure ulcer that was identified on 9/17/23. A record review of Resident 35's Change of Condition assessment dated [DATE] indicated Resident 35 developed a stage II pressure ulcer to the sacral that measured .0.4 (L-length) x0.5 (W-width) x0.1 (D-depth) [wounds measured in centimeters] to sacrum . A record review of Resident 35's Change of Condition assessment dated [DATE], indicated Resident 35 developed a stage III pressure ulcer to the sacrum that measured .3.5(L)x1.0(W) x0.3 (D) to sacrum . A record review of Resident 35's progress note, dated 11/7/23 was conducted. This note indicated, Chief Complaint .Wound Care Visit . an assessment was completed for a stage 3 [stage III] pressure ulcer to the sacrum and noted on 10/24/23-Pressure ulcer now st. 3 [stage III] .10/31/23-Pt [patient] wound not much improvement, continue with same tx [treatment] . A joint observation and interview were conducted on 2/15/24 at 8:20 AM, with CNA 23 in Resident 35's room. CNA 23 stated they did not have evidence of documentation that Resident 35 was turned and repositioned. CNA 23 stated Resident 35 should had been repositioned more frequently due to Resident 35's pressure ulcer. Observations of Resident 35 were conducted on the following dates and times: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 2/12/24 at 8 A.M., 9:10 A.M, 11:01 A.M., 2:21 P.M., and 5:24 P.M., Resident 35 was lying upright in bed, directly on her sacrum (referred to the tailbone), on an air pressure pad (APP- alternating pressure pad/mattress that alleviates pressure). A wedge pillow (triangle pillow used to redistribute body weight; helpful for positioning to prevent pressure sores/injuries) was on the bed, but not used. On 2/13/24 at 9 A.M., 11:30 A.M, 1:45 P.M., 3:30 P.M., and 5:45 P.M., Resident 35 was lying upright in bed, directly on her sacrum, on an APP. A wedge pillow was on the bed, but not used. On 2/14/24 at 7:10 A.M., Resident 35 was lying upright in bed. A wedge pillow was positioned on the right side of her upper back with Resident 35's sacrum directly on the APP. On 2/14/24 at 9:10 A.M., Resident 35 was lying upright in bed, directly on her sacrum, on an APP. A wedge pillow was on the bed, but not used. On 2/14/24 at 10:21 A.M., Resident 35 was lying upright in bed. A wedge pillow was positioned on the left side of her upper back with Resident 35's sacrum directly on the APP. On 2/14/24 at 12:21 P.M., Resident 35 was lying upright in bed. A wedge pillow was positioned on the right side of her upper back with Resident 35's sacrum directly on the APP. On 2/14/24 at 2:24 P.M., Resident 35 was lying upright in bed on an APP, directly on her sacrum. A wedge pillow was on the bed, but not used. On 2/15/24 at 7:30 A.M., Resident 35 was lying in a partially upright position on an APP with her sacrum directly on the bed. A wedge pillow was positioned on the right side of her upper back. On 2/20/24 at 7:55 A.M., 10 A.M., and 12:25 P.M., Resident 35 was lying in a partially upright position on an APP, with her sacrum directly on the bed. A wedge pillow was positioned on the right side of her upper back. On 2/20/24 3:24 P.M., Resident 35 was lying in an upright position on an APP, slightly turned, with her sacrum directly on the bed. A wedge pillow was positioned on the left side of her upper back. A joint observation and interview were conducted on 2/13/24 at 9:39 A.M., with licensed nurse (LN) 31 in Resident 35's room. A wedge pillow was on the bed, but not used. LN 31 stated Resident 35's stage III pressure ulcer was slightly bigger and measured 3.7 (L) x 1.6 (W) x 0.4 (D). LN 31 stated she could not find a care plan related to Resident's 35 stage II pressure ulcer that was identified on 9/17/23. LN 31 stated, there was no documentation to show that Resident 35 was repositioned to address the Resident's pressure ulcer. An interview and record review was conducted on 2/13/24 at 1:04 P.M., with LN 31. LN 31 stated Resident 35 was at high risk for developing pressure ulcers due to bowel and bladder (B/B) incontinence (loss of bladder control) and dependence on staff for repositioning. LN 31 also stated it was important for Resident 35 to be repositioned to avoid the development of new pressure ulcers as well as decline of existing pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An interview with the Director of Nursing (DON) was conducted on 2/20/24 at 8:52 A.M . The DON stated there was no evidence of documentation that Resident 35 was turned and repositioned frequently after a stage II pressure ulcer that was identified on 9/17/23. The DON acknowledged Resident 35's pressure ulcer deteriorated from stage II to stage III on 11/7/23, almost 2 months later. The DON stated staff should have been turning Resident 35 more frequently to prevent further decline of Resident 35's pressure ulcer. A review of the facility's policy titled, Pressure Injury Prevention revised August 12, 2016, was conducted. This policy indicated .The Nursing staff will implement interventions identified in the Care Plan on the individual risk factors . B. Repositioning and Turning . Other Risk Factors to consider A. Co-morbidities as Diabetes Mellitus, End Stage Renal Disease, Cancer, Vascular Disease, CVA [stroke], prior history of Pressure Injuries .C. Cognitive impairment that affects the communication and active participation of the resident in the plan of care . A review on the facility's undated lesson plan titled, Pressure Injury Management was conducted. The lesson plan indicated, Positioning Guidelines-Prevention . turn or reposition the resident's body at least every two hours . RULE OF 30 DEGREES Position the resident's body to avoid laying over existing ulcer or wound HOB [head of bed] <30 degrees. Note: The use of pressure relieving surfaces does not replace turning and repositioning .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38512 Based on observation, interview and record review, the facility failed to: 1. Consistently evaluate Fall Risk Assessments and conduct Care Conferences after each resident fall, in order to prevent future falls for two of four residents (Residents 19, 49), reviewed for falls, and 2. Complete continuous quarterly safety smoking evaluations for five of five residents reviewed for smoking (Resident 22, Resident 60, Resident 5, Resident 21, and Resident 26). As a result, there was the potential for additional falls with possible injuries and for residents who smoked to be at risk for smoking-related burn injuries. Findings: 1a. Resident 19 was admitted to the facility on [DATE] with diagnoses to include dementia (the loss of the ability to think, remember and reason, to levels that affect daily life and activities), per the facility Admission Record. On 2/12/24 at 11:46 A.M., Resident 19 was observed in his room, in bed. Resident 19's mattress had bolsters on each side, approximately four inches high, four inches wide, and 36 long. The bolsters were attached to the mattress, and were covered with a fitted sheet. In addition fall mats were on the floor on either side of the bed. Resident 19 indicated, using gestures, that the bolsters were to prevent him from falling. On 2/20/24 a record review was conducted. Resident 19's MDS, (an assessment tool) listed a cognitive score of 3, indicating severely impaired cognition. Resident 19's was coded for two or more falls since admission. Per the documentation, Resident 19 fell on the following dates: 9/21/23 9/28/23 10/11/23 12/5/23 12/11/23 1/22/24 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 19's numeric fall risk assessment was completed on 9/20/23. Resident 19's Fall Risk Assessment score was 23, indicating high risk for falls. Resident 19's initial care plan, dated 9/21/23, indicated Resident 19 was at high risk for falls. The interventions included fall mats and frequent monitoring. Later on 9/21/23, Resident 19 had a fall. No Post Fall Risk Evaluation scores were documented. After the fall on 9/28/23: Post (after) Fall Risk Evaluation score was lowered from 23 to 13. No new interventions were implemented on the fall care plan. After the fall on 10/11/23: Post Fall Risk Evaluation score remained the same at 13, with no new interventions implemented on the fall care plan. After additional falls on 12/5/23, 12/11/23, and 1/22/24, No Post Fall Risk Evaluation scores were documented. No new interventions were implemented on the fall care plan. 39220 1b. Resident 49 was admitted to the facility on [DATE] with diagnoses which included hemiplegia (weakness on one side of the body), following cerebral infarction (stroke) affecting the left side, per the facility's Admission Record. On 2/12/24 at 11:36 A.M., an observation was conducted of Resident 49 during initial tour, while he laid in bed. Resident 49 was restless and moving around in bed. The head of the bed was elevated at 30 degrees. The bed was in a low position and fall mats were on both sides of the bed. Resident 49 did not respond to questions, and seemed to become more agitated when spoken to, responding in unintelligible grunts. On 2/13/24, Resident 49's clinical record was reviewed: The quarterly MDS (a clinical assessment tool), dated 1/19/24, listed a cognitive score of 00, indicated cognition was severely impaired. The functional abilities assessment indicated extensive staff assistance was required for transfers, personal care, and activities of daily living. The care plan, titled tendency to lose balance during transfers and decreased safety awareness, dated 8/8/23, listed an intervention of physical therapy to treat as indicated and safety awareness training. The fall risk assessment score at the time was 17, indicating a high risk for falls. According to the nurse's progress note, dated 9/8/23 at 9:17 A.M., Resident 49 had an unwitnessed fall (Fall #1) in his room and had minor bleeding from the mouth. Resident 49 was transported to the hospital for evaluation. A Post (after) Fall Risk Evaluation was completed on 9/8/23 at 10:31 A.M., leaving the fall risk score the same at 17. Per the nurses note, dated 9/8/23 at 4:17 P.M., the resident returned to the facility with no new physician orders. There was no documented evidence a post fall Care Conference (when department heads meet to discuss a change in condition and to implement more care interventions to prevent future falls) meeting was conducted. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan, titled High Risk for Falls, date 9/8/23, (not actual fall), listed interventions such as anticipate the needs of the resident, floor mats x 2, physical therapy to evaluate and treat, implement safety precautions. According to the nurses note, dated 9/28/23 at 6:18 A.M., Resident being monitored for witnessed fall. (Fall #2) A hospital transfer form, dated 9/28/23, indicated Resident 49 was transported to the hospital for evaluation after a fall. There was no documentation of how the resident fell or when. There was no documented evidence a post fall Care Conference was conducted or a Post Fall Risk Evaluation. There was no change in the High Risk for Falls care plan. According to the nurse's notes dated 10/9/23 at 3:55 P.M., Resident 49 had an unwitnessed fall (Fall #3) in his room and was found on the fall mat. A Post Fall Risk Evaluation was not completed. There was no documented evidence a post fall Care Conference was conducted. A care plan was developed, titled Actual Fall, dated 10/9/23, with interventions of floor mats x 2, continue interventions on the at-risk plan, maintain bed at low position, and determine and address causative factors of the fall. According to the nurse's notes dated 10/19/23 at 1:05 A.M., Resident 49 was found lying on floor in his room (Fall #4). The resident was moved to a room closer to the nurse's station. The Post Fall Risk Evaluation score remained the same at 17 and no post fall Care Conference was completed. The fall was added to care plan, titled Actual Fall, dated 10/9/23, with no changes or revisions in fall interventions. According to the nurse's notes dated, 10/21/23 11:34 P.M., Resident 49 had an unwitnessed fall in his room (Fall #5) and was found sitting on the floor mat next to his bed. A right elbow skin tear was noted and the resident was sent to the hospital for evaluation. A Post Fall Evaluation was conducted on 10/21/23 at 11:42 P.M., and the fall risk score was lowered from 17 to 15. There was no documented evidence a post fall Care conference was conducted. The care plan, titled Actual Fall, did not document the fall on 10/21/23, and fall interventions were not revised or added to prevent future falls. According to the nurse's notes, dated 11/4/23 at 10:31 P.M., Resident 49 was found on the floor in his room (Fall #6). The Post Fall Risk Evaluation, dated 11/4/23, score was lowered from 15 to 11. A post fall Care Conference was completed which listed interventions of: Physician/Psychiatrist to evaluate medications, nursing to make rounds every shift x 72 hours and perform urinalysis to rule out urinary tract infection. According to the Post Fall Evaluation, dated 11/13/23 at 11:55 P.M., Resident 49 had an unwitnessed fall in his room (Fall # 7). A Post Fall Risk Evaluation score was lowered again from 11 to 7. The Post Fall Care Conference listed interventions of: Physician/Psychiatrist to evaluate medications, nursing to make rounds every shift x 72, physical therapy to continue, notify State representative. According to the nurses note dated 11/19/23 at 9:15 A.M., Resident 49 had an unwitnessed fall in his room (Fall #8). The Post Fall Risk Evaluation score was increased from 7 to 9. The Post Fall Care Conference listed interventions of, Physician/Psychiatrist to evaluate medications, nursing to make rounds every shift x 72, pending psych evaluation, frequent checks by staff to ensure safety. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to Post Fall Evaluation, dated 12/10/23 at 2 A.M., Resident 49 had an unwitnessed fall in his room (Fall #9). The Post Fall Evaluation had pre-fall assessment score of 11, and a post fall assessment score of 11, with no change in the risk level. The resident had a right elbow skin tear and was transported to the hospital for evaluation. The post fall Care Conference listed interventions of safety precautions, psych evaluation, physician to increase Buspar (a mind-altering medication that treats anxiety) and to re-start Lorazepam (a mind-altering medication that treats anxiety). According to the nurse's notes, Resident 49 had additional unwitnessed falls in his room on 12/26/23 at 1:50 A.M. (Fall #10) and again on 1/24/24 at 12:23 A.M. (Fall #11) There was no documented evidence Post Fall Risk Evaluations were completed. The post fall Care Conference listed interventions of Visual checks every 30 minutes, safety precautions, call light in place, bed in low position, physician to increase Lorazepam. On 2/14/24 at 8:04 A.M., an interview was conducted with CNA 11. CNA 11 stated if a resident was found on the floor, she would stay with the resident and call for help. CNA 11 stated the LNs would come and assess the resident to make sure no injuries occurred. CNA 11 stated the LNs were responsible calling the physician and notifying the family. On 2/15/24 at 7:50 A.M., an interview was conducted with LN 1. LN 1 stated if a resident fell , the LNs were responsible for documenting the fall, such as when, where, how etc. and notifying the physician and family. The LNs would then perform Post Fall Risk Evaluation, to determine the risk of future falls. LN 1 stated, if residents had falls, the fall risk score should increase each time, because the risk is higher based on the actual falls. LN 1 stated with each fall, more interventions should be put in place, in order to prevent future falls. LN 1 stated after each fall, the department heads would meet in a care conference to discuss the fall and to determine why it happened and what they could do to prevent future falls. LN 1 stated Post Fall Risk Evaluations and Care Conferences were automatically performed after every fall. On 2/15/24 at 8:17 A.M., an interview was conducted with the ADON. The ADON stated Care Conferences were important to complete after falls to determine the cause, and to implement new interventions. The ADON stated Post Fall Risk Evaluation scores should go up, indicating a higher risk, and should never go down in score. On 2/20/24 at 8:23 A.M., an interview and record review was conducted with the DON. The DON stated whenever a resident had a fall, she expected LNs to perform a Post Fall Risk Evaluation, which tallied factors and provided a score risk for future falls. The DON stated the higher the score, the higher the fall risk. The DON stated anyone with a score over 10 was considered a high risk, and it triggered fall interventions to be put in place to prevent future falls. The DON stated after falls, the care conference team should meet for a fall Care Conference to determine the root cause of the fall and to discuss interventions to prevent future falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON reviewed Resident 49's fall history. The fall on 9/8/23, had no post fall Care Conference and the Post Fall Risk Evaluation score did not increase, but stayed the same at 17. The fall on 9/28/23, had no post fall Care Conference and no Post Fall Risk Evaluation was competed. The fall on 10/19/23, had no post fall Care Conference and no Post Fall Risk Evaluation completed. The fall on 10/21/23, had no post fall Care conference and the Post Fall Risk Evaluation score went down to 15, instead of up. The fall on 11/4/23 had a post fall Care conference, but the Post Fall Risk Evaluation score dropped down from 15 to 11. With the fall on 11/13/23, the Post Fall Risk Evaluation dropped to 7, meaning he was no longer a high risk. On the 11/19/23 fall, the Post Fall Risk Evaluation went up to 9, with post fall Care Conference being completed for the remaining falls on 12/10/23, 12/26/23, and 1/24/24, and eventually the Post Fall Risk Evaluation returning to 17, as high fall risk. The DON continued, stating they tried a one-to one sitter for Resident 49, but did not document that in the notes, care conferences or on the intervention, which would have been important to show they were trying to prevent the falls. The DON stated she expected Care Conferences to be done after all falls and post Fall Risk Evaluations to be accurate. According to the facility's policy, titled Fall Management Program, dated March 2021, .D. The IDT (Interdisciplinary Team ie. Care Conference) will initiate, review and update the resident's fall risk status and care plan .upon identification of a significant change of condition, post falls, and as needed .Post Fall Response: A. Following every resident fall, the licensed nurse will perform a post-fall evaluation and update, initiate and revise the Resident care plan as necessary .C. The IDT will investigate the fall including a review of the Resident's medical record . 48263 3a. On 2/20/24, a review of Resident 22's Admission Record indicated Resident 22 was admitted in the facility on 12/7/20 with diagnoses that included a history of hemiplegia (paralysis of one side of the body) following cerebral infarction (stroke). Resident 22's document titled, Smoking Evaluation, dated 12/10/21, indicated Resident 22 was a smoker and supervision with smoking was required. There was no documented evidence any additional smoking evaluations were completed. 3b. On 2/20/24 a review of Resident 60 Admission Record indicated Resident 60 was admitted to the facility on [DATE] with diagnoses that included paraplegia (paralysis of the lower part of the body). Resident 60's document titled, Smoking Evaluation dated 3/21/23 indicated a Resident 60 was a smoker. There was no documented evidence any additional smoking evaluations were completed. 3c. On 2/20/24 a review of Resident 5's Admission Record indicated Resident 5 was admitted on [DATE] with diagnoses that included a history of hemiplegia (paralysis of one side of the body) following cerebral infarction (stroke). Resident 5's document titled, Smoking Evaluation, dated 11/29/21 indicated Resident 5 was a smoker and was unable to light a cigarette safely. There was no documented evidence any additional smoking evaluations were completed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3d. On 2/20/24 a review of Resident 21's Admission Record indicated Resident 21 was admitted to the facility on [DATE] with diagnoses that included a history of cerebral infarction (stroke). Resident 21's document titled, Smoking Evaluation dated 6/8/22 indicated Resident 21 was a smoker and was unable to light cigarettes safely, extinguish and use an ashtray to extinguish a cigarette. There was no documented evidence any additional smoking evaluations were completed. 3e. On 2/20/24, a review of Resident 26's Admission Record indicated Resident 26 was admitted to the facility on [DATE] with diagnoses that included a history of chronic obstruction pulmonary disease (a lung disease). Resident 26's document titled, Smoking Evaluation dated 10/30/23 indicated Resident 26 was a smoker and was unable to light cigarettes safely and extinguish safely. There was no documented evidence any additional smoking evaluations were completed. On 2/20/24 at 8:09 A.M., a joint interview and record review was conducted with MDSN 1. MDSN 1 stated smoking assessments should be completed on a quarterly basis (every three months). MDSN 1 stated it was important to re-evaluate any residents who smoked due to safety reasons. MDSN 1 stated quarterly assessments were needed because changes to a resident's condition could happen, for example their ability to hold a cigarette. An interview with the DON was conducted on 2/20/24 at 8:47 A.M. The DON stated it was her expectation the quarterly evaluations for smoking be conducted for all residents who smoke. The DON stated safety concerns could result due to a lack of ongoing smoking assessments. A review of facility's policy titled, Smoking by Residents, revised January 2017 indicated, Procedure . VI. Using the Resident Smoking Assessment ., the Licensed Nurse will assess residents who express a desire to smoke, upon admission quarterly, annually and upon significant change of condition identification .

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38512 Based on observation, interview and record review, the facility failed to ensure a recommendation for diet changes related to weight loss was followed up for one of three residents reviewed for nutrition (Resident 21). This failure had the potential to affect the health and well-being of Resident 21. Findings: Resident 21 was admitted to the facility on [DATE] with diagnoses to include dementia (memory loss) and protein-calorie malnutrition (a type of undernutrition that occurs when not enough protein and calories were eaten), per the facility Admission Record. On 2/12/24 at 12:40 P.M., an observation of Resident 21 was conducted during lunch. Resident 21 had consumed less than half of the foods provided on the tray. Resident 21 was wheeling away from the tray, and indicated he did not want more food by waving his hand at it as he wheeled away. Dining room staff offered Resident 21 a nutritional supplement (NS, a drink which provides protein and calories) but Resident 21 refused. On 2/13/24 at 8:32 A.M., an observation of Resident 21 was conducted during breakfast. Resident 21 had eaten less than half of the foods provided on his breakfast tray. Resident 21 stated he was finished and did not want more food. On 2/20/24, a record review was conducted. On 11/29/23, Resident 21s Minimum Data Set (MDS, an assessment tool), Brief Interview for Mental Status (BIMS) score was 12, indicating moderate cognitive impairment. The nutrition section of the MDS indicated Resident 21 had lost 5% or more of his body weight in the last month, or a loss of 10% or more of his body weight in the last six months, and not on a prescribed weight loss regimen. Per the physician orders, dated 11/22/23, Resident 21 was prescribed a carbohydrate controlled diet (CCHO, a diet low in simple sugars, used for diabetes management), with a NS three times each day with meals. On 8/20/23, RD 1 documented Resident 21 had had significant weight loss over the previous four months, calculating a loss of 5% of his body weight over the previous month, a loss of 8.7% body weight over the previous three months, and a loss of 15.3% body weight over the previous four months (since admission). RD 1 recommended the removal of the CCHO diet to allow Resident 19 more choices of foods to encourage improved intake. On 9/29/23, RD 1 recommended reducing the supplements to one a day at breakfast to reduce the risk of supplement fatigue and encourage the intake of whole foods. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/20/24 at 11:55 A.M., a telephone interview was conducted with RD 2. RD 2 stated she was familiar with Resident 21. RD 2 stated if she wanted to make diet changes, she would leave a note with her recommendations for the physician to sign, or get a nurse to write a diet order. RD 2 stated she was not aware of RD 1's suggestion to liberalize the CCHO diet, or to reduce the amount of supplements. RD 2 stated she had no knowledge of why the recommendations to change the diet and supplement were not completed. Per RD 2, Weight loss can have dire consequences in this population. On 2/20/24 at 12:26 P.M., a concurrent interview and record review was conducted with the ADON. The ADON stated when a RD made a recommendation, it should be communicated to the nurses. Then the nurse would call the physician to obtain an order. The ADON stated if the physician had said no to the recommendation, the nurse would inform the RD. Per the ADON, she could not speak to why the RD recommendations were not implemented. The ADON stated she did not know who called the physician to request the diet changes, but the changes had not been made. On 2/20/24 at 4:28 P.M., an interview was conducted with Resident 21's physician (MD 2). MD 2 stated neither the RD or a nurse had contacted him about Resident 21's weight loss, or dietary recommendations. MD 2 stated he was not sure Resident 21 was still assigned to him, and stated he had not ordered any labs in awhile to assess nutritional status. MD 2 stated he typically ordered whatever the RD recommended. Per a facility policy, revised June of 2018 and titled Nutritional Status Evaluation Committee, .The weight of residents will be monitored for variance and the Nutritional Status Evaluation Committee .will intervene when appropriate .V. Objectives of the Nutritional Status Evaluation Committee .B. Evaluating changes in diet, food preferences, and increased caloric intake .G. Identifying behaviors in the feeding environment that may be contributing to weight loss .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on observation, interview, and record review, the facility failed to date and time enteral tube feedings (a method of delivering nutrition in liquid form into the stomach through a tube), feeding for two of two residents (Resident 49 and Resident 81), reviewed for tube feedings. As a result, there was the potential for Resident 49 and 81 to have complications related to the tube feedings and/or risk for infections. Findings: 1. Resident 49 was admitted to the facility on [DATE], with diagnosis which included hemiplegia (weakness on one side of the body), following cerebral infarction (stroke), affecting the left side and moderate protein-calorie malnutrition, per the facility's Admission Record On 2/12/24 at 8:46 A.M., during initial tour, an observation was conducted of Resident 49 in his room. Resident 49 was restless in bed and non-verbal. The head of the bed was elevated at 30 degrees and next to the bed was an enteral pump (a machine that delivers tube feeding formula at a specific rate/per hour to the gastrointestinal tract). The pump was off and hanging above the enteral pump, was a clear plastic bag labeled Jevity 1.5. (a nutritional formula). Inside the clear plastic bag was brown formula remaining, measuring at 550 cubic centimeters (cc) on the bag's measuring line. Next to the formula was another clear bag which contained 525 cc of clear flush solution. The two bags labeled Jevity and flush, were not labeled or dated of when they were first hung or administered. On 2/12/24 at 3:00 P.M., an observation and interview was conducted with LN 11. LN 11 stated Resident 49's tube feeding was hung at 10 P.M., each night at 60 cc hour and was turned off at 8 A.M., the following morning. LN 11 observed Resident 49's tube feeding in his room, which was not infusing at the time. LN 11 stated the tube feeding bag was not dated and timed of when it was hung, and the flush fluid was also not labeled. LN 11 stated if the bags were not labeled, LNs did not know how long they have been hanging and might be past the allowable time frame. LN 11 stated the formula could grow bacteria and cause an infection to the resident's intestinal tract, if infused. LN 11 stated it was a nursing standard of practice to label, date and time any fluids that were infused into the body. On 2/12/24 at 3:05 P.M., an interview was conducted with the ADON. The ADON stated all enteral formulas needed to be labeled with the date and time when they were first administered, so it would not extend over 24 hours. The ADON stated dating and timing a formula was a quality and safety issue to prevent bacteria growth. On 2/13/24, Resident 49's clinical record was reviewed: According to the physician's order, dated 9/17/23, provide and serve supplements as ordered: Jevity 1.5 at 60 cubic centimeters (cc) an hour for 10 hours a day. Water flush: 60 cc an hour for 10 hours a day = 600 cc a day of water. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly MDS (a clinical assessment tool), dated 1/19/24, listed a cognitive score of 00, indicated cognition was severely impaired. 38512 2. Resident 81 was readmitted to the facility on [DATE] with diagnosis to include stroke, dysphagia (difficulty swallowing) and moderate protein-calorie malnutrition, per the facility Admission Record. On 2/12/24 at 10:31 A.M., Resident 81 was observed asleep in bed, with a tube feeding container hanging on his right side. The tube feeding was not infusing. Approximately 500 milliliters (ml) remained in the 1000 ml container. The tube feeding product was labeled by the manufacturer with the product name. A second white label was on the bag, with three lines for rate, start time/date, and end time/date. The white label had Resident 81's name written, but the rate, start time/date and end time/date were blank. A second bag of water hung next to the tube feeding bag, containing approximately 1000 ml of water. The bag of water had a white label indicating Resident 81's name but the rate, start time and end time were blank. On 2/12/24, Resident 81's clinical record was reviewed. Per a physician's order, dated 12/27/23, Resident 81 was to receive a tube feeding at 70 ml of tube feeding every hour between 12 P.M. and 8 A.M. The water flush was indicated as 30 ml every hour until 600 ml had infused. Per a RD note, dated 12/6/23, Resident 81 would meet his estimated nutritional and fluid needs with the tube feeding running as ordered. On 2/12/24 at 10:59 A.M., an interview was conducted with LN 2. LN 2 stated Resident 81's tube feeding had been started the previous day at 12 P.M., and was turned off at 8 A.M. that day. LN 2 stated the label did not have the information needed to know if Resident 81 had received the tube feeding. LN 2 stated, We cannot tell if he got the tube feeding or not, because the dates are not on the label. LN 2 stated the previous nurse had not written the time he started the tube feeding or the water bag. LN 2 stated it was important to write the start time and date to confirm Resident 81 received the nutrition the physician had ordered. On 2/12/24 at 11:45 A.M., an interview was conducted with the DON. The DON stated it was her expectation all nurses wrote start date and time, as well as end date and time for all tube feedings and water flushes. The DON stated it was important to ensure the tube feeding was dated to prevent infection, and to ensure the residents received their tube feeding as ordered. On 2/15/24 at 9:35 A.M. an interview was conducted with the DSD. The DSD stated she could not locate any documentation that the facility had provided tube feeding training or any in-services to the LNs for the past two years. According to the facility's policy, titled Enteral Feeding-Closed, dated January 2012, .VIII. Label the formula container and tubing with date and time hung .

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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. 48263 Based on observation, interview, and record review, the facility failed to identify a resident's source of pain for one of one residents reviewed for pain management (Resident 7). This failure had the potential for Resident 7 to experience unrelieved pain. (Cross Reference F656) Findings: A review of Resident 7's Admission Record indicated Resident 7 was admitted to facility on 4/1/23 with diagnoses that included a history of dementia (memory loss) and a left humerus (upper arm bone) fracture. A record review of Resident 7's Minimum Data Set (MDS- an assessment tool) dated 12/26/23, indicated Resident 7's cognitive skills to make daily decisions was moderately impaired. On 2/15/24 at 10:48 A.M., an observation of Resident 7 was conducted. Resident 7 could be heard yelling from the hallway several rooms away. Resident 7 was in bed, lying down. Resident 7 continued yelling, and waving her hands. On 2/15/24 at 10:48 A.M., a concurrent observation and interview was conducted with CNA 22 in Resident 7's room. CNA 22 stated Resident 7 yelled when she wanted something, such as being repositioned for comfort. On 2/15/24 at 10:55 A.M., an interview was conducted with LN 22. LN 22 stated Resident 7 complained about pain during transfers and showers. LN 22 stated he had not administered any pain medications recently to Resident 7. On 2/15/24 at 2:44 P.M., a joint interview and record review was conducted with LN 22. LN 22 stated Resident 7 participated in the Restorative Nursing Assistant (RNA, specialized CNA) program, and usually complained of left arm and left knee pain. LN 22 referred to Resident's 7's physician order dated 5/11/23 and stated that Resident 7 had an order for Tylenol (medication for pain) as needed, but Resident 7 had not been medicated for pain in some time. LN 22 stated it would be beneficial for Resident 7 to be pre-medicated for pain management prior to RNA program. A joint interview and record review was conducted on 2/20/24 at 8:24 A.M., with MDSN 1 (a nurse that conducts long term care assessments). MDSN 1 stated she did not know Resident 7 complained of pain during transfers and movement of her upper and lower extremities. MDSN 1 stated all residents should have pain assessments on admission, every three months, and when a change of condition was identified. MDSN 1 was not able to identify any pain assessments. An interview with the DON was conducted on 2/20/24 at 9:15 A.M. The DON stated pain should be evaluated and addressed, including indicators such as body language, facial expressions and mood. The DON stated Resident 7's pain and pain triggers were not identified. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility's policy titled, Pain Management dated 2022 indicated under .2. Pain Management . i. The IDT will review the residents Pain Management and make changes to the care plan as needed . 4. Documentation . c. The Licensed Nurse will update the Care Plan for pain management with any change in treatment and/or medication.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38512 Based on observation, interview and record review, the facility failed to ensure the physician (MD 2) supervised and managed the care of one of three residents reviewed for nutrition (Resident 21). This failure had the potential for Resident 21 to experience additional weight loss and other medical complications affecting his overall well-being. Cross reference: F692, F657 Findings: Resident 21 was admitted to the facility on [DATE] with diagnoses to include dementia (memory loss), protein-calorie malnutrition (a type of undernutrition that occurs when not enough protein and calories were eaten), and diabetes (a condition that affects how the body turns food into energy), per the facility Admission Record. On 2/12/24 at 12:40 P.M., an observation of Resident 21 was conducted during lunch. Resident 21 had consumed less than half of the foods provided on the tray. Resident 21 was wheeling away from the tray, and indicated he did not want more food by waving his hand at it as he wheeled away. Dining room staff offered Resident 21 a nutritional supplement (NS, a drink which provides protein and calories) but Resident 21 refused. On 2/13/24 at 8:32 A.M., an observation of Resident 21 was conducted during breakfast. Resident 21 had eaten less than half of the foods provided on his breakfast tray. Resident 21 stated he was finished and did not want more food. On 2/20/24, a record review was conducted. On 11/29/23, Resident 21s Minimum Data Set (MDS, an assessment tool), Brief Interview for Mental Status (BIMS) score was 12, indicating moderate cognitive impairment. The nutrition section of the MDS indicated Resident 21 had lost 5% or more of his body weight in the last month, or a loss of 10% or more of his body weight in the last six months, and was not on a prescribed weight loss regimen. Per the physician orders, dated 11/22/23, Resident 21 was prescribed a carbohydrate controlled diet(CCHO, a diet low in simple sugars, used for diabetes management), with a NS three times each day with meals. On 8/20/23, RD 1 documented Resident 21 had had significant weight loss over the previous four months, calculating a loss of 5% of his body weight over the previous month, a loss of 8.7% body weight over the previous three months, and a loss of 15.3% body weight over the previous four months (since admission). RD 1 recommended the removal of the CCHO diet to allow Resident 19 more choices of foods to encourage improved intake. On 9/29/23, RD 1 recommended reducing the supplements to one a day at breakfast to reduce the risk of supplement fatigue and encourage the intake of whole foods. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/30/23, a Nurse Practitioner (NP), working with MD 2, documented a progress note for Resident 21. The progress note indicated Resident 21 had had no new decline or emergencies, and had no concerns. The NP documented Resident 21 was stable. There was no documentation regarding weight loss or poor intake. On 8/7/23, MD 2 documented Resident 21 had no injury, and planned to continue his current care. There was no documentation regarding weight loss or poor intake. On 11/29/23, the NP documented Resident 21 had no wounds and was stable. The NP documented, Per staff no concerns. Per the NP, Resident 21 had gone to the emergency room due to low blood sugar when he had not eaten well one evening, but returned to the facility when stabilized. There was no documentation regarding weight loss or poor intake, or any discussion regarding diet changes. On 2/20/24 at 11:55 A.M., a telephone interview was conducted with RD 2. RD 2 stated she was familiar with Resident 21. RD 2 stated if she wanted to make diet changes, she would leave a note with her recommendations for the physician to sign, or get a nurse to write a diet order. RD 2 stated she was not aware of RD 1's suggestion to liberalize the CCHO diet, or to reduce the amount of supplements. RD 2 stated she had no knowledge of why the recommendations to change the diet and supplement were not implemented. Per RD 2, Weight loss can have dire consequences in this population. On 2/20/24 at 12:26 P.M., a concurrent interview and record review was conducted with the ADON. The ADON stated when a RD made a recommendation, the RD could call the physician and ask a nurse to take an order, or the RD could ask a nurse to contact the physician with the recommendations. The ADON stated if the physician had said no to the recommendation, the nurse would inform the RD. Per the ADON, she could not speak to why the RD recommendations were not implemented. The ADON stated she did not know who called the physician to request the diet changes, but the changes had not been made. On 2/20/24 at 4:28 P.M., an interview was conducted with Resident 21's physician (MD 2). MD 2 stated neither the RD or a nurse had contacted him about Resident 21's weight loss, or dietary recommendations. MD 2 stated he was not sure Resident 21 was still assigned to him, and stated he had not ordered any labs in awhile to assess nutritional status. MD 2 stated he typically ordered whatever the RD recommended. Per a facility policy, revised June of 2018 and titled Nutritional Status Evaluation Committee, .The weight of residents will be monitored for variance and the Nutritional Status Evaluation Committee .will intervene when appropriate .V. Objectives of the Nutritional Status Evaluation Committee .B. Evaluating changes in diet, food preferences, and increased caloric intake .G. Identifying behaviors in the feeding environment that may be contributing to weight loss .

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 47466 Based on interview and record review, the facility failed to ensure staff were competent in managing residents with diabetes (abnormal blood sugar levels) for one of three residents reviewed for closed record review (Resident 51). This failure had the potential to negatively affect Resident 51's health. Findings: A review of Resident 51's Admission Record indicated Resident 51 was admitted in the facility on 1/10/24 with a diagnosis that included diabetes. An interview was conducted on 2/14/24 at 8:27 A.M., with LN 1. LN 1 stated Resident 51 was sent to the hospital on 1/31/24 due to a low blood sugar of 43 milligrams per deciliter (mg/dl, where a normal range is approximately 70 - 110). LN 1 stated, it was very important to check residents' blood sugars to prevent episodes of high or low blood sugars. LN 1 stated the physician should be notified for any blood sugar results that were outside of the normal range. LN 1 stated she had been employed by the facility for one year. On 2/14/24 at 4:25 P.M., an interview and record review of the Medication Administration Record (MAR) with LN 22 was conducted. LN 22 stated if no blood sugars were documented in the MAR, as ordered by the physician, then there was no evidence it was completed. LN 22 stated all of his diabetic training was from nursing school, and he had not received any education or training while employed at the facility. LN 22 stated she had been employed by the facility for one year. On 2/20/24 at 8:43 A.M., an interview and joint record review was conducted with LN 34. LN 34 stated if the blood sugar was 70 mg/dl or below, the facility's low blood sugar protocol instructed the LNs to give orange juice, milk, or soft drinks until blood sugars were above 70. LN 34 stated LNs should then repeat the blood sugar test every 15 minutes until it was within the normal range. LN 34 stated abnormal blood sugars and patient's response should be documented in the nursing progress notes. LN 34 stated the nurse should inform the physician for any abnormal blood sugars. LN 34 stated she had her diabetes training while she was in nursing school, and she had not received any education or training while employed at the facility. LN 34 stated she had been employed by the facility for about one year. An interview and record review on 2/20/24 at 11:14 A.M., with the DON was conducted. The DON stated we had their last annual skills check (a competency training) in September 2022, which included diabetes management. The DON stated staff competency training should be completed upon hire, and annually afterwards. A review of the facility's policy, dated 3/17/2022, and titled Staff Competency Assessment, .Competency assessments will be performed upon hire during the employee's 90-day employment period, annually .VI. The annual evaluation of an employee will include review of completed competency assessments which may have been done throughout the year .

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 48263 Based on observation, interview, and record review, the facility failed to ensure the nurse staffing data was posted and readily accessible to the residents and public, and to accurately document the total number and actual hours worked by the nursing staff. As a result, staff and the public were unaware of the daily facility staffing. Findings: On 2/12/24 at 10:37 A.M., during an initial tour of the facility, the posted staffing data reflected a date of 2/7/24 (five days prior). Staffing data is required to be posted daily for public view. On 2/14/24 at 3:26 P.M., during an interview with the DSD, the DSD stated the staff posting was missed and had not been posted from 2/8/24 through 2/12/24. The DSD stated she was responsible for the staff posting, but she had been off work for the past five days. The DSD stated in her absence, she expected the staffing to be posted by team leaders. The DSD stated it was important the staff data be posted to let the residents and visitors know they had sufficient nursing staff available. On 2/14/24 at 3:35 P.M., during an interview with the DON, the DON stated it was important to have a staff posting displayed in public for all to see. A review on the facility's policy revised 7/2018, and titled Nursing Department-Staffing, Scheduling & Posting indicated, .Nurse Staffing Posting . A. The facility will post the following information on a daily basis: I. Facility name, II. The current date, III. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff responsible for resident care per shift . B. Posting requirements . I. The Facility will post the nurse staffing data specified above, on a daily basis at the beginning of each shift .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 39220 Based on observation, interview, and record review, the facility failed to document non-pharmaceutical interventions or gradual dose reductions (GDR) for three of five residents (Resident 3, 42, and 10) reviewed for unnecessary medication review. As a result, Resident's 3, 42 and 10 did not have non-pharmaceutical interventions attempted and Gradual Dose Reductions were not initiated per Federal and State regulations. Findings: 1. Resident 3 was readmitted to the facility on [DATE], with diagnoses which include dementia (progressive memory loss) and schizoaffective disorder, (a mental disorder that is marked by schizophrenia symptoms such as hallucinations and delusions), per the facility's Admission Records. ` On 2/13/24, Resident 3's clinical record was reviewed. According to the quarterly MDS, dated [DATE], a cognitive score of 3 was listed, indicating cognition was severely impaired. According to the physician orders, dated 11/22/23, Memantine (medication for memory loss) 10 milligrams (mg) two time a day for monitoring related to dementia, Mirtazapine (Medication to treat depression and obsessive-compulsive disorder) 30 mg at bedtime for depression, and Seroquel 50 (medication used for schizophrenia) mg two times a day for mental disorders. Monitor for episodes of extrapyramidal symptoms (impaired motor control), depression (sadness) and for side effects. Hallucinations (hearing voices or seeing things that are not there) and for physician listed side effects. According to the Medication Administration Records, (MAR) from January 1, 2024 through February 15, 2024, Resident 3 displayed no episodes of specific behaviors and did not exhibit any side effects. The care plan titled, Psychotropic medications dated 9/12/23, listed interventions of: Consult with pharmacy, MD to consider dosage reduction, Discuss with MD, family re: ongoing need for the use of medication. Review behaviors, interventions and alternate therapies attempted, Monitor/record occurrence of target behavior symptoms. The Medication Regimen Review (MRR- when a consulting pharmacist (CP) makes medication recommendations on a monthly basis) was reviewed from [DATE] through January 2024. The following CP recommendations were made for Resident 3, during the December 2023 review: Metazeptine 30 mg tab at night time, please assess for annual assessment: target behavior Irritable behavior, episodes so far this month, zero, side effect so far this month, zero. Dose reduction recommended at this time, please document rationale if you disagree. There was no documented evidence that the physician agreed or disagreed and the CP recommendation of a GDR, and it did not appear it was acted on. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident 42 was readmitted to the facility on [DATE], with diagnoses which included dementia (progressive memory loss) with behavior disturbances, per the facility's Admission Record. On 2/13/24, Resident 42's clinical record was reviewed. According to the quarterly MDS, dated [DATE], a cognitive score of 3 was listed, indicating severely impaired cognition. The physician's order dated 9/12/23, listed Citalopram (medication for depression) 20 mg every day, Rexulti (medication for antipsychotic-mood disorder) 0.5 mg every day and Trazadone (medication for (anxiety/depression) 50 mg at nighttime. Monitor for episodes of behaviors, depression (sadness) and for listed side effects. Hallucinations (hearing voices or seeing things that are not there) and for side effects, an anxiety or restlessness. According to the Medication Administration Records, (MAR) from January 1, 2024, through February 15, 2024, Resident 42 displayed no episodes of specific behaviors and did not exhibit any side effects. The care plan titled antidepressant, Citalopram, dated 9/12/23, listed interventions of Monitor behaviors and Monitor/report behaviors side effects. The care plan, titled psychotropic, Rexulti, dated 9/12/23, listed interventions of Consult with pharmacy, MD to consider drug dosage reduction, discuss with MD/family regarding the ongoing need for use of medication, monitor and document any adverse reactions. The MRR was reviewed from [DATE] through January 2024. The following CP recommendations were made for Resident 42 during the November 2023 review, Rexulit 0.5 mg and Trazadone 50 mg at night, please assess for annual assessment: target behavior psychosis and depression, episodes so far this month, zero, side effect so far this month, zero. Dose reduction recommended at this time, please document rationale if you disagree. There was no documented evidence that the physician agreed or disagreed with the CP recommendation of a GDR, and it did not appear it was acted on. On 2/15/24 at 9:43 A.M., an interview was conducted with the SSD. The SSD stated they previously were doing psychotropic medication reviews every month and she was responsible for scheduling and organizing the meetings. The SSD stated the psychotropic medication care conferences consisted of the Admin, MD, DON, ADON, and the SSD. The SSD stated the last psychotropic care conference conducted was in April 2023, and none had not been performed since then. The SSD stated when the facility merged with the hospital in April 2023, other issues took precedent. The SSD stated over the past 10-months, she had informed the three previous Administrators and the current one, to let them know psychotropic review was a Federal and State requirement and needed to be performed. The SSD continued, stating during a psychotropic medication care conference, they evaluate the medication, number of behaviors displays, side effects and non-pharmaceutical interventions preformed. The purpose of these care conference to was to determine if the medication was still necessary or could the dosage be reduced, because psychotropic medications could be harmful. The SSD stated the harm to the resident could result from the medication or the dose of medication was no longer required. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/15/24 at 10:28 A.M., an interview was conducted with LN 13. LN 13 stated staff monitored resident behaviors and signs of possible signs side effects daily for all resident's on psychotropic medication. LN 3 stated monitoring was important so the psychotropic committee could evaluate the necessity of the medication and if the dosage should be increased or decreased, based on the behavior monitoring. LN 13 stated it was the MD who changed the medication dosage after discussing it with the family and evaluating the necessity for change. On 2/15/24 at 2:46 P.M. an interview and record review was conducted with LN 14. LN 14 stated LNs should attempted non-pharmaceutical interventions first, before administering a psychotropic medication for a behavior outburst. LN 14 stated non-pharmaceutical interventions were things like, placing the resident in a quiet room, play soft music, hold their hand, or turn off the lights. LN 14 reviewed Resident 3 and Resident 42's MAR from January 1, 2024 through February 15, 2024 for non-pharmaceutical interventions attempts. LN 14 stated no nonpharmological interventions were attempted or documented. LN 14 noted Resident 3 received a one time injection of Ativan 2 (an antianxiety medication) mg on 1/16/24, to treat aggression, but it was not documented as a behavior and no nonpharmological interventions were documented prior to the injection. On 2/20/24 at 7:45 A.M., an interview was conducted with the MD. The MD stated he managed the psychotropic medication review care conference and they were normally meet every month to discuss issues. The MD stated he would change medication dosages based on review of the resident's medical record and discussing with the rest of the committee members. The MD stated they have not had any care conferences for psychotropic medication review for several months. The MD stated the committee was, behind the boat and residents could be taking higher dosage then they needed, because gradual dose reductions were not being attempted. The MD stated with the facility change in April 2023, the psychotropic medications were not a primary focus, and it should have been. On 2/20/23 at 8:23 A.M., an interview was conducted with the DON. The DON stated care conference for psychotropic review was important to evaluate behaviors, side effects, dose reductions, and non-pharmaceutical interventions. The DON stated the since these reviews were not being conducted, there was a break in the system for evaluating the necessity of psychotropic medications. The DON stated the harm could be that the resident may no longer require the higher dose, since their health was declining, and the behaviors were diminishing. According to the facility's policy titled, Behavior/Psychotropic Drug Management, dated November 2018, II Interventions: A Non-pharmacological interventions .ii. The Licensed nurse will notify and collaborate with the Attending Physician/Prescriber, family member, resident, Responsible Party and/or IDT members regarding the identified contributing to the resident's mood/behavior problems .iii. The Licensed Nurse will document the interventions taken and recommendations in the resident's Care Plan.B. Psychotropic Drug Interventions . v. Dosage reduction or re-evaluation are provided according to OBRA regulations .a .1. If the anti-psychotic Antipsychotic was initiated within the last year, the facility has attempted a gradual dose reduction (GDR) in two separate quarters (with at least one month between attempts) .3. If no antipsychotic GDR has been attempted, the prescriber has documented a tapering is clinically contraindicated . 48263 3. A review of Resident 10's clinical record titled, Admission Record indicated Resident 10 was admitted to the facility on [DATE] with diagnoses which included a history of depression. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 10's Minimum Data Set (MDS- a nursing assessment tool) dated 1/17/24 , indicated Resident 10 had a Brief Interview for Mental Status of 4 (BIMS - score 0 to 7 suggested severe cognitive impairment). On 2/14/24 at 4:29 P.M., a record review of Resident 10's Medication Regimen Review (MRR) was conducted from November 2023 thru January 2024. The MRR for Resident 10's Sertraline indicated, Please add behavior monitoring for the resident. On 2/14/24 at 4:30 P.M., a record review of Resident 10's clinical record titled, Psychiatric F/U (follow up) Note, dated 1/2/24 indicated, Resident 10 was on Sertraline (medication used for mood disorders, which can positively affect mood) 150 mg (milligrams). The Psychiatric F/U Note stated .I recommend decreasing Sertraline to 125mg . On 2/14/24 at 4:31 P.M., a review of Resident 10's record for Sertraline medication was conducted. There was no evidence of documentation that Sertraline was decreased per the psychiatrist recommendation. An interview and joint record review of Resident 10's clinical record with the DON was conducted on 2/20/24 at 10:38 A.M. The DON stated that Resident 10's MRR for behavior monitoring was not followed up due to missed psychotropic meetings. The DON stated it was important to monitor behaviors to determine recommendations for the psychiatrist to review the appropriateness for GDRs. A review of facility's policy and procedure dated November 2018 titled, Behavioral/Psychotropic Drug Management, indicated B. Psychoactive Drug Interventions . d. Psychopharmacological medications (other than antipsychotropics and sedative hypnotics) .GDR in two separate quarters (with at least one month between attempts) . F. Any order for psychoactive medication should include . Specific behavior manifested .

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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. 48263 Based on observation, interview and record review, the facility failed to label and store medications properly when: 1. A medication was left unsecured and unmonitored at a nurses station, 2. A medication was stored improperly within a medication cart, and 3. An Automated Drug Dispensing System (ADDS) was not being monitored for temperature controls. These failure had the potential for accidental ingestion of an unprescribed medication, and for medications to be at risk for degradation. Findings: 1. On 2/12/24 at 12:48 P.M., an observation and interview was conducted at the east wing nursing station with LN 23. An unattended and unlabeled medication cup with two Tylenol (a medication used for pain management) pills was left at the edge of the nursing station table within wheelchair height. LN 23 acknowledged that that unattended medication was meant for a co-worker who was complaining of a headache. LN 23 stated that medications should not have been left unattended due to the safety concerns for facility residents, staff and visitors to easily reach medications while unattended with the potential for medication errors or safety concerns. An interview with the DON was conducted on 2/20/24 at 9 A.M. The DON stated that medications should not have been left unattended due safety concerns for medication errors, adverse reactions and misuse of medication. Review of facility's policy and procedure revised 10/2018, Ron's Pharmacy Policy and Procedure, indicated . Drugs shall be accessible only to personnel designated in writing by the licensee . 38512 2. On 2/14/24 at 9:58 A.M., a concurrent observation and interview was conducted with Licensed Nurse (LN) 1. LN 1 opened a locked drawer on a medication cart to demonstrate where inhalers were stored. One medication, Breztri Aerosphere inhaler, was removed. LN 1 read the instructions printed on the Breztri box, which indicated to write a date on the box of when the foil pouch had been opened. Per LN 1, no date had been written. LN 1 read the instructions, which were to discard the inhaler when either the inhaler was empty, or within three months of opening the foil pouch, whichever comes first. LN 1 stated she would not know when the inhaler was opened as there was no date written on the box, and the foil pouch was missing. LN 1 stated not storing the medication properly could mean the resident was given a medication that was not effective due to being outdated. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/14/24 at 10:10 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated it was her expectation nursing staff followed all instructions on medications. The DON stated if medications were not stored properly, they might not provide work as intended by the ordering physician. Per the DON, the facility utilized the Ron's Pharmacy Policy and Procedure Manual. Per the facility's reference, Ron's Pharmacy Policy and Procedure Manual, revised 10/2019, .XI. Medication Labeling & Proper Storage: All medications .must be properly labeled . Per the Breztri Aerosphere packaging insert, revised 1/2022, .Breztri Aerosphere should be discarded when the dose indicator display window shows zero .or 3 months .after removal from the foil pouch, whichever comes first . 3. On 2/15/24 at 9:05 A.M., a concurrent observation of the ADDS and interview with the Assistant Director of Nursing (ADON) was conducted. The ADDS was located within a nursing station. No thermometer or temperature monitoring sheet was observed. The ADON stated she was not aware of whether the facility monitored the temperature of the area. Per the ADON, the medications within the ADDS would be the same temperature as the nursing station. On 2/15/24 at 10 A.M., an interview was conducted with the Pharmacy Consultant (PC). The PC stated the medications within the ADDS needed to be maintained at an appropriate temperature. The PC stated maintaining temperatures where the ADDS was located was how the facility would ensure the medications were safe. The PC stated she was not aware of the facility's policy regarding checking the temperature surrounding the ADDS. On 2/15/24 at 11:07 A.M., an interview was conducted with the Director of Maintenance (DM). The DM stated he took temperatures each day in resident rooms, but did not take temperatures in the nurses station. Per the facility Ron's Pharmacy Policy and Procedure, revised 10/2018, .K. Temperature of Medications: Drugs shall be stored in appropriate temperatures. A. Drugs required to be stored at room temperature shall be stored at a temperature between .59 degrees F (Fahrenheit) and 86 degrees F. 1. Recommend a temperature log for daily documentation .

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on observation, interview, and record review, the facility failed to follow food preferences during meal service for one of two residents, (Resident 73) reviewed for choices. As a result, Resident 73 felt ignored and disrespected. Findings: Resident 73 was admitted to the facility on [DATE] with diagnoses which include malignant neoplasm (cancer) of head, neck and face, per the facility's Admission Record. On 2/12/24 at 11:52 A.M., an observation was conducted of Resident 73 in the dining room. Resident 73 was sitting with others at a table, drinking coffee, and waiting for lunch to arrive. On 2/12/24 at 12:07 P.M., the lunch trays arrived in the dining room and were delivered individually by staff. On 2/12/24 at 12:28 P.M., an observation and interview were conducted with Resident 73 while in the dining room. Resident 73's meal ticket was viewed, which read Dislikes: milk (milk substitutes okay to provide). On Resident 73's lunch tray was a full, untouched glass of milk. Resident 73 stated they served her milk with every meal, despite her request to not have milk. Resident 73 stated she never drank the milk served and believed it was wasteful to keep serving it and then throwing it away. Resident 73 stated the facility was not acknowledging her dislike of milk and she felt disregarded. On 2/13/24, Resident 73's clinical record was reviewed: According to the physician's order, dated 10/2/23, the diet was listed as mechanical soft, (soft, cut up with small bite sizes) texture regular/thin consistency, for difficulty swallowing due to malignancy. The quarterly MDS (a clinical assessment tool), dated 12/25/23, listed a cognitive score of 12, indicating cognition was intact. On 2/13/24 at 10:13 A.M., an interview was conducted with the DSS. The DSS stated the kitchen does not have any milk substitutes. On 2/13/24 at 1:17 P.M., an interview was conducted with Resident 73. Resident 73 stated they still gave her milk last night, this morning, and again at lunch. Resident 73 stated It's like they don't read dislikes and it makes me angry. On 2/14/24 at 12:48 P.M., an interview was conducted with the RD-C. The RD-C stated resident preferences and dislikes should be honor. The RD-C stated he spoke to Resident 73 on 2/12/23 and asked if she would like soy milk or lactose milk instead, which she said she was willing to try. The RD-C stated he had not implemented an alternate milk substitute yet. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/14/23 at 12:51 P.M., an interview was conducted with the DSS. The DSS stated Resident 73's preferences were not being followed and they needed to be honored it, because was a resident's right. On 2/15/24 at 8:45 A.M., an interview was conducted with the DON. The DON stated she expected all resident food preferences to be honor and respected. The DON stated following resident food preferences was a resident's right. According to the facility's policy, titled Dietary Profile and Resident Preference Interview, dated April 2022, . III. Resident Preferences will be reflected in the medical record and tray-card and updated in a timely manner .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 39220 Based on observation, interview and record review, the facility failed to store, date, and protect food under sanitary conditions in one of two freezers (mobile kitchen freezer), reviewed for kitchen sanitation. This improper food safety practice had the potential to cause foodborne illness and/or food contamination. Findings: On 2/12/24 at 8:19 A.M., during initial kitchen tour with the DSS, an observation was conducted in the mobile kitchen freezer. On the left side of the freezer, on a middle shelve was a clear plastic bag of approximately 10 dinner rolls. The plastic bag was knotted, and contained no date or label of when the bag was opened. On the same shelve was a partially opened bag of parmesan cheese. An expiration date could not be seen on the commercial bag of cheese. On 2/12/24 at 8:20 A.M., an interview was conducted with the DSS. The DSS stated the dinner rolls and parmesan were not sealed and dated and they should have been. The DSS stated the foods could have caused foodborne illness if served to residents. On 2/13/24 at 9:52 A.M., an interview was conducted with the RD-C. The RD-C stated all freezer and refrigerator items needed to be dated when opened, so staff were aware of when they should be discarded. The RD-C stated food packages needed to sealed before placing them in the freezer to preserve the taste, quality, and to prevent freezer burn. On 2/15/24 at 8:45 A.M., an interview was conducted with the DON. The DON stated she expected the kitchen staff to promote safe food practices and to store food according to the guidelines. According to the facility's policy, titled Receiving Food and Supplies, dated June 2023, Food and supply items will be received and handled in accordance with recommended sanitary practices to prevent foodborne illnesses.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 38512 Based on interview and record review, the facility did not ensure Governing Body had an effective oversight and necessary resources for resident care services. Governing Body (the entity responsible for establishing and implementing facility policies) failed to ensure effective oversight and necessary resources to ensure resident care services were met to attain or maintain the highest practical physical, mental, and psychosocial well-being of each resident. This failure had the potential to affect the quality of care to residents. Cross Reference: F726, F732, F841 and HSC 1418.8, F865, F867, F868, F880, F887, Title 22 72541 Findings: On 2/15/24, a record review of facility documents was conducted. An undated document, titled Governing Body Preparation and Review, indicated: Items to review prior to the Governing Body Meeting for Discussion: .QAPI Plan .B. Review of internal reportable events: pressure ulcers that occurred or worsened, .falls with significant injury .equipment malfunction .Discuss any revisions needed to Facility Assessment .Discuss Performance Improvement Projects (PIPs) in place (QAPI) and progress, Look at training and in-service provided for QAPI program, Discuss facility leadership challenges . An undated Organizational Chart indicated the Nursing Home Administrator directly reported to Chief Executive Officer. Per a facility policy, revised 5/18/22 and titled Standardization of District Policies and Procedures, 1.0 Purpose: 1.1 To establish processes for the development, revision, approval and implementation of policies and procedures in a standardized format throughout Pioneers Memorial Healthcare District (PMHD) 3.11 Imperial Heights Healthcare and Wellness Center (the former name of Pioneers Memorial Skilled Nursing Center) 3.11.1 This facility will establish policies and procedures that will give guidance for quality oversight; resident and operational practices; and regulatory compliance. 3.11.3 Oversight: 3.11.3.1 PMHD will have a representative at the facility's Policy and Procedures Committee . (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per a facility policy, revised 5/18/22 and titled Organization Performance Improvement Plan, 1.0 Purpose: 1. 1 To provide a formal ongoing process by which the organization and stakeholders utilize objective measures to monitor and evaluate quality of service, patient safety and risk reduction strategies .3.2.4 PMHD Board of Directors and Senior Leadership are accountable and responsible for establishing a culture of continual improvement by dedicating adequate resources for measuring, assessing, improving and sustaining organizational quality, safety, and risk reduction .3.8 Maintaining Accreditation and Regulatory Compliance Committee (MARCC), a multidisciplinary committee with representatives from the Administrative Team .functions to: 3.8.1 Direct continuous survey readiness activities and monitors effectiveness, .3.8.2 Focus on evaluation/'improvement of a specifically identified processes or care practice 3.8.3 Collaborate and approve policies . On 2/20/24 at 5:08 P.M., an interview was conducted with the Admin, DON, ADON and Regional Consultant (RC). Per the Admin, the Governing Body met monthly. The Admin stated he had last met with the Governing Body two weeks prior. Per the ADON, We are all still learning how to communicate with each other .

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. 39220 Based on interview and record review, the facility's Medical Director (MD 1) did not oversee care area concerns related to psychotropic drug (mind-altering drugs) use and Gradual Dose Reductions (GDR) for 38 out of 83 residents, listed on the facility Matrix currently receiving psychotropic medications. As a result, 38 residents were not having their psychotropic medications evaluated monthly, and their care needs were not addressed in a timely manner such as no psychotropic care conferences and no GDR were attempted for nine months. (Cross reference to F-758 and H&S Code 1418.8) Findings: On 2/20/24 at 7:45 A.M., an interview was conducted with the facility's MD 1. MD 1 stated he was in charge of the management team for all residents receiving psychotropic medication. MD 1 stated the management team was expected to meet monthly, evaluate nonpharmacological interventions, determine the amount of behaviors exhibited, the number of side effects displays, and to determine if the medication was still required or could the dose be reduced. MD 1 stated the Consulting Pharmacist (CP) also reviewed each resident's medication regime on a monthly basis and send recommendations to him for review. MD 1 stated if he agreed with the recommendation, such as a GDR, he would sign it and sent it to the DON and the order would be changed to what the physician thought was appropriate. If the MD disagreed, he was required to write a justification of why he disagreed, and the document would also be sent to the DON. MD 1 continued, stating he was the primary person reviewing and handling the psychotropic medications at the facility. MD 1 stated they had not had any psychotropic committee conferences for several months and that included GDR's. MD 1 stated the facility got behind and the psychotropic reviews were not being done, which could be harmful to residents. MD 1 stated reviews and GDRs were important because the medications had side effects that could be harmful. MD 1 stated facility's committee was, behind the boat and residents could be taking higher dosage then they needed. MD 1 stated since the facility changed ownership, psychotropic medications were not a primary focus, and it should have been. According to the facility's Medical Directorship Agreement, dated August 1, 2023, .2. Directorship Services provided herein shall include the following: a. Supervision and Oversite. Director will supervise and oversee the health services provided at the SNF (skilled nursing facility) as outlines in Exhibit B (Medical Director Duties). According to the Exhibit B, titled Medical Director Duties, undated, The responsibilities of the Director shall include, but not limited to the following: 1. Provide medical direction and coordination for the health care activities and services provided by the health care staff. 2. Implement and review resident care .integrated delivery of care . 3. (2) review residents' condition and program of care at each visit, including medications and treatment .

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 38512 Based on interview and record review, the facility failed to develop an effective Quality Assurance Performance Improvement (QAPI) program, when the committee did not consistently track, address, and follow up on quality issues affecting the residents as follows: 1. The call light system was not functional for several days. Cross reference: Title 22, 72541 2. Infection control practices were not implemented when Covid immunizations were not offered to residents. Cross reference F887 3. A pressure ulcer worsened for a resident. Cross reference F686 4. Haircuts were not offered to residents over an 10-month period. Cross reference F676 5. A resident with diabetes had unidentified hypoglycemia for two days, leading to a 10-day hospitalization . Cross reference F684 6. Gradual Dose Reductions (GDRs) were not routinely performed for residents on antipsychotic medications. Cross reference F758, HSC 1418.8 7. The Medical Director failed to provide oversite regarding GDR's. Cross Reference F841 These failures placed all residents at risk for accidents, infections, worsening physical and psychosocial harm. Findings: On 2/20/24, a record review was conducted. A facility policy, revised 1/1/12 and titled, Quality Assessment and Assurance Committee - Composition & Duties, indicated, Purpose: To promote the quality of resident care by overseeing, identifying, tracking, addressing and follow-up on all quality issues .Procedure: I. Meetings and Minutes A. The QAA Committee meets monthly . Per a facility documented, updated 11/17/20 and titled QAPI Plan, .The QAPI plan will guide the facility's performance improvement efforts .Purpose of Facility's QAPI Plan: Our facility's written QAPI plan provides guidance for our overall quality improvement program .Decisions will be made to promote excellence in quality of care, quality of life, resident choice, person directed care .Focus areas will include all systems that affect resident and family satisfaction, quality of care and services provided, and all areas that affect the quality of life for persons living and working in our facility .The administrator has responsibility and is accountable to the governing body for ensuring that QAPI is implemented throughout our facility .Our facility will conduct Performance Improvement Projects (PIP) that are designed to take a systematic approach to revise and improve care or services in areas that we identify as needing attention . (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/20/24 at 5:08 P.M., an interview was conducted with the Admin, DON, ADON, and Regional Consultant (RC). Per the Admin, the last QAPI meeting had been on 10/10/23. The Admin stated the QAPI members had identified problems, but had not sat down formally to conduct a proper QA meeting. Regarding the malfunctioning call light system, the Admin stated QAPI was aware of the problem but had not determined a Performance Improvement Plan and the facility had not reported the issue to CDPH or implemented a safety watch. The DON and ADON stated the QAPI meeting in October had reviewed infection rates, but was not made aware of the lack of Covid vaccines being offered. Per the RC, pressure ulcers were a part of the QAPI committee discussion, and improvement had been seen. The Admin stated offering haircuts was part of their routine care, but since the hospital had acquired the facility, a contract was necessary and had not been arranged. The Admin stated the haircuts should have been included in QAPI, but they had not escalated the concern to the status it needed to be resolved. The DON stated diabetes management should have been a QAPI discussion, as well as staff training and education. The DON stated GDRs were identified as an issue for QAPI, but the previous administrator had no plan developed. The Admin stated more QAPI interventions would have been appropriate to help identify problems and solutions.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 38512 Based on interview and record review, the facility failed to have an effective Quality Assurance Performance Improvement (QAPI) program, when the committee did not consistently track, address, and follow up on quality issues affecting the residents as follows: 1. The call light system was not functional for several days. Cross reference Title 22 72541 2. Infection control practices were not implemented when Covid immunizations were not offered to residents. Cross reference F887 3. A pressure ulcer worsened for a resident. Cross reference F686 4. Haircuts were not offered to residents over an 11-month period. Cross reference F676 5. A resident with diabetes had unidentified hypoglycemia for two days, leading to a 10-day hospitalization . Cross reference F684 6. Gradual Dose Reductions (GDRs) were not routinely performed for residents on antipsychotic medications. Cross reference F758, HSC 1418.8 7. The Medical Director did not provide oversite to the identification of problem-prone QAPI interventions. Cross Reference F841 These failures placed all residents at risk for accidents, infections, worsening physical and psychosocial harm. Findings: On 2/20/24, a record review was conducted. A facility policy, revised 1/1/12 and titled Quality Assessment and Assurance Committee - Composition & Duties, indicated, Purpose: To promote the quality of resident care by overseeing, identifying, tracking, addressing and follow-up on all quality issues .Procedure: I. Meetings and Minutes A. The QAA Committee meets monthly . (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Per a facility documented, updated 11/17/20 and titled QAPI Plan, .The QAPI plan will guide the facility's performance improvement efforts .Purpose of Facility's QAPI Plan: Our facility's written QAPI plan provides guidance for our overall quality improvement program .Decisions will be made to promote excellence in quality of care, quality of life, resident choice, person directed care .Focus areas will include all systems that affect resident and family satisfaction, quality of care and services provided, and all areas that affect the quality of life for persons living and working in our facility .The administrator has responsibility and is accountable to the governing body for ensuring that QAPI is implemented throughout our facility .Our facility will conduct Performance Improvement Projects (PIP) that are designed to take a systematic approach to revise and improve care or services in areas that we identify as needing attention . On 2/20/24 at 5:08 P.M., an interview was conducted with the Admin, DON, ADON, and Regional Consultant (RC). Per the Admin, the last QAPI meeting had been on 10/10/23. The Admin stated the QAPI members had identified problems, but had not sat down formally to conduct a proper QA meeting. Regarding the malfunctioning call light system, the Admin stated QAPI was aware of the problem but had not determined a Performance Improvement Plan and the facility had not reported the issue to CDPH or implemented a safety watch. The DON and ADON stated the QAPI meeting in October had reviewed infection rates, but was not made aware of the lack of Covid vaccines being offered. Per the RC, pressure ulcers were a part of the QAPI committee discussion, and improvement had been seen. The Admin stated offering haircuts was part of their routine care, but since the hospital had acquired the facility, a contract was necessary. The Admin stated the haircuts should have been included in QAPI, but they had not escalated the concern to the status it needed to be resolved. The DON stated diabetes management should have been a QAPI discussion, as well as staff training and education. The DON stated GDRs were identified as an issue for QAPI, but the previous administrator had no plan developed. The Admin stated more QAPI interventions would have been appropriate to help identify problems and solutions.

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Pioneers Memorial Skilled Nursing Center	320 Cattle Call Dr. Brawley, CA 92227

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 38512 Based on interview and record review, the facility Quality Assurance Performance Improvement (QAPI) committee failed meet at least quarterly, and as needed to develop meaningful activities that identified areas for improvement. This failure had the potential to affect the safety and quality of care provided to residents. Cross reference: Title 22 72541, F887, F686, F676, F684, F758, HSC 1418.8. Findings: On 2/20/24, a record review was conducted. Per a facility documented, updated 11/17/20 and titled QAPI Plan, .The QAPI plan will guide the facility's performance improvement efforts .Framework for QAPI: .The QAA committee will meet a minimum quarterly and as needed . On 2/20/24 at 5:08 P.M., an interview was conducted with the Admin, DON, ADON, and Regional Consultant (RC). Per the Admin, the last QAPI meeting had been on 10/10/23. The Admin stated the QAPI members had identified problems, but had not sat down formally to conduct a proper QA meeting. Per the Admin, .I can't deny more QAPI committee meetings would be helpful . A facility policy, revised 1/1/12 and titled Quality Assessment and Assurance Committee - Composition & Duties, indicated, Purpose: To promote the quality of resident care by overseeing, identifying, tracking, addressing and follow-up on all quality issues .I. Meetings and Minutes A. The QAA Committee meets monthly .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 39111 Based on observation, interview, and record review, the facility failed to ensure one Staff 21 adhered to proper glove use and hand hygiene (acceptable methods for cleaning hands such as handwashing or using hand sanitizer) while bringing soiled linens into the facility laundry. This deficient practice had the potential to spread harmful microorganisms around the facility which could lead to residents developing infections. Findings: On 2/15/24 at 3:12 P.M., an observation was conducted in the hallway near the laundry room. Staff 21 was observed entering the facility's back entrance wearing a personal protection gown and gloves. Staff 21 was pushing a barrel containing soiled linens into the building. Staff 21 stopped at the back entrance and applied hand sanitizer to her gloved hands. Staff 21 then continued to push the linen barrel into the building and into the laundry room. On 2/15/24 at 3:15 P.M., an interview was conducted with Staff 21. The housekeeping supervisor (HS) was also present. Staff 21 stated she should not have used hand sanitizer on her gloves. On 2/15/24 at 3:24 P.M., a joint interview was conducted with the HS and the ADON. The ADON stated applying hand sanitizer to gloves was not an acceptable hand hygiene or glove use practice. The ADON stated, If you need to put sanitizer on them [gloves] then take them off and throw them away. Then use hand sanitizer on your hands. On 2/20/24 at 3:35 P.M., an interview was conducted with the DON. The DON stated, It's never acceptable to hand sanitize your gloves. A review of the facility's documents titled Inservice Meeting Minutes for Hand Hygiene and Washing Before and After dated 8/25/23, Wear of Gloves [sic] and Hand Hygiene dated 9/27/23, and Covid Isolation Disinfectant/Hand hygiene dated 1/23/24, indicated Staff 21 had attended the inservice trainings. The lesson plan for the inservices included, Do's & Don'ts for Wearing Gloves in the Healthcare Environment .Don't re-use or wash gloves . Don't substitute glove use for hand hygiene .Don't forget to remove and dispose of gloves properly A review of the facility's policy titled Hand Hygiene revised September 1, 2020, indicated, .The facility considers hand hygiene the primary means to prevent the spread of infections. Hand hygiene means cleaning your hands by handwashing (washing hands with soap and water), antiseptic hand wash or antiseptic hand rub . B. Wearing gloves does not replace the need for hand hygiene

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 39111 Based on interview and record review, the facility failed to: 1. Offer/re-offer/administer COVID-19 vaccinations to five residents (56, 30, 73, 52, 55) sampled for COVID-19 vaccination and 34 residents (64, 55, 81, 85, 193, 2, 22, 84, 40, 19, 15, 76, 79, 1, 26, 83, 39, 56, 11, 5, 33, 23, 67, 80, 17, 51, 78, 82, 44, 31, 36, 190, 240, 192) newly admitted to the facility after 9/14/23. 2. Accurately document COVID-19 vaccination refusals on the facility's vaccination tracking list. 3. Implement their policy and procedure titled COVID-19 Vaccination Program. As a result of this deficient practice, there was the potential for residents, staff, and visitors to be placed at risk for COVID-19 infection. Findings: A review of the facility's document titled All Admissions, dated 2/20/24, indicated there were a total of 36 residents (64, 55, 81, 85, 193, 2, 22, 84, 40, 19, 15, 76, 79, 1, 26, 83, 39, 56, 11, 5, 33, 23, 67, 80, 17, 51, 78, 82, 44, 31, 36, 190, 240, 192, 30, 56) newly admitted after the facility reopened on 9/14/23 (to current date 2/20/24). A review of the facility's document titled Infection Control Surveillance dated January 2024, indicated 50 residents had tested positive for COVID-19. Of the 36 residents admitted to the facility after 9/14/23, twenty residents (81, 85, 30, 193, 84, 19, 76, 79, 1, 26, 39, 56, 5, 33, 23, 17, 78, 82, 44, 36) had tested positive for COVID-19 in January 2024. A review of the facility's undated and untitled resident vaccination tracking log, indicated there were 57 residents listed as having refused the COVID-19 vaccine. Upon further review, Resident 56 was identified on the vaccine tracking log as having refused the COVID-19 vaccine. On 2/15/24 at 8:35 A.M., an interview was conducted with Resident 56 while inside the resident's room. Resident 56 stated he had been a resident in the facility for about four months. Resident 56 stated he had not been offered the COVID-19 vaccine upon admission nor during his stay in the facility. Resident 56 stated he had not received the COVID-19 vaccine, was never offered it, and did not refuse it. Resident 56 stated he would like to receive it. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/20/24 at 7:50 A.M., a joint interview was conducted with the ADON and IPN 22. IPN 23 joined the interview by telephone. IPN 23 stated the facility had a COVID-19 vaccination clinic in March 2023, and that was the last time the facility had offered COVID-19 vaccinations to its residents. IPN 23 stated when the facility reopened in September 2023, she had not offered/re-offered/administered COVID-19 vaccines to residents who were readmitted . IPN 23 stated the facility began admitting new residents starting September 2023 and they had also not been offered/administered COVID-19 vaccinations. IPN 23 stated the facility had a COVID-19 outbreak in January 2024. IPN 23 stated COVID-19 vaccinations should have been offered/re-offered/administered to residents to prevent COVID-19 infections and outbreaks. IPN 23 further stated she had documented on her vaccination tracking log that residents had refused COVID-19 vaccines. IPN 23 stated she had done that because she had not offered them to residents. On 2/20/24 at 3:35 P.M., an interview was conducted with the DON. The DON stated when the facility reopened in September 2023, they should have started offering/re-offering/administering COVID-19 vaccinations to the readmitted residents. The DON stated residents who were newly admitted to the facility should have also been offered/administered COVID-19 vaccinations. A review of the facility's policy titled COVID-19 Vaccination Program revised March 15, 2022, indicated, .The facility will offer SARS-CoV-2 [COVID-19 virus] vaccinations (including additional and booster doses) to all residents . A. the resident's vaccination status will be evaluated upon admission. I. If the resident has not been vaccinated prior to admission they will be provided with vaccine information and offered the vaccine within seven days of admission. II. If the resident is partially vaccinated, the date of the next dose (if required) or a booster dose (if requested) will be added to the vaccine administration log

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38512 Based on observation, interview, and record review, the facility failed to assure that resident rooms housed no more than four residents. Two rooms had the potential to accommodate five residents in each room (rooms [ROOM NUMBERS]). Seven rooms had the potential to accommodate six residents in each room (Rooms 2, 3, 4, 5, 13, 15, and 18). As a result, the potential existed to impact resident care and quality of life. Findings: On 2/12/24 through 2/20/24, observations were conducted during the course of the annual recertification survey at the facility. Additionally, interviews and records reviews were conducted. There were no observed quality of care or quality of life concerns related the number of residents in the rooms. A continuance of the waiver (variation) from the requirements of 42 CFR section 483.70(d)(1)(i) as granted pursuant to a letter from the Centers for Medicare and Medicaid Services (CMS), dated January 25, 2019, and allowing more than four residents per room, is hereby recommended. This recommendation is also made with the expectation that the facility will obtain a timely renewal of the current waiver (variation) granted by CMS as reflected in the January 25, 2019 letter to the facility from CMS.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38512 Based on observation, interview, and record review, the facility failed to assure that resident rooms measured at least 80 square feet per resident in resident room [ROOM NUMBER]. As a result the potential existed to impact resident care and quality of life. Findings: On 2/12/24 through 2/20/24, observations were conducted during the course of the annual recertification survey at the facility. The facility had one multiple resident room (room [ROOM NUMBER]) which did not meet the minimum 80 square feet per resident. room [ROOM NUMBER] measured 479 square feet and had the potential to house six residents. The allocated space for each resident would measure 79.83 square feet. The six residents occupying the room had no complaints. There were no observed quality of care or quality of life concerns that negatively impacted the residents residing in the identified room. A continuance of the waiver (variation) from the requirements of Code 42 of the Federal Regulations (CFR) section 483.70(d)(1)(ii) as granted pursuant to a letter from the Centers for Medicare and Medicaid Services (CMS), dated January 25, 2019, and allowing less than 80 square feet per resident per room per room, is hereby recommended. This recommendation is also made with the expectation that the facility will obtain a timely renewal of the current waiver (variation) granted by CMS as reflected in the January 25, 2019 letter to the facility from CMS.