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	01/10/2025

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

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45063 Based on observation, interview and record review, the facility failed to ensure confidential information was kept private for one of five sampled residents (Resident 28). As a result, Resident 28's right to privacy and confidentiality was violated. Findings: Resident 28 was re -admitted to the facility on [DATE] with diagnoses which included Acute Prostatitis (painful inflammation of the prostate gland), Local infection of the skin and subcutaneous tissue and Urinary Tract Infection per Facility's Admission Record. On 1/7/25 at 7:05 P.M., an observation of nursing station One was conducted. The Vital signs record of Resident 28 was seen on the counter of nursing station one unattended. The vital signs record contains Resident 28's name, room number, blood pressure, pulse, temperature, respiratory rate, bowel movement consistency, and oxygen saturation. On 1/9/25 at 11:45 A.M., an interview with Infection Preventionist/Registered Nurse (IP/RN) was conducted. The IP/RN stated vital signs record are part of medical records. The IP/RN stated all medical records, including vital signs record should be kept secure and confidential. The IP/RN acknowledged by not keeping vital signs record secure and unattended, anybody can see a resident's information. The IP/RN stated vital signs record should had been secured in a manila folder for privacy but was not done. On 1/10/25 at 5:45 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated vital signs record of residents should had been kept secure and not left unattended exposed to public. The DON stated resident 28's right to privacy and confidentiality was violated. Per the facility's policy and procedure (P&P) titled, Disclosure of PHI, Medical records Manual - HIPAA revised December 1, 2012, the P&P indicated Procedure I . D. ii. Medical Records Use and Storage: a. Facility staff will keep medical records secure and confidential b. Care should be taken to keep a medical record shielded and inaccessible to other residents or to the general public .

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 43674 Based on observation, interview and record review, the facility failed to provide communication tool for 2 of 18 sampled residents (Resident 13 and Resident 36). As a result, there was a potential for Resident 13 and Resident 36 to not be able to communicate their needs to staff and effect their quality of life. Findings: 1. Resident 13 was admitted to the facility on [DATE] with diagnoses which included dementia (a decline in mental abilities that affects thinking, memory, and behavior), hemiplegia (paralysis of one side of the body), and urinary retention (unable to empty urine in bladder) per Resident 13's Admission Record. Observations were conducted on 1/7/25 at 12:30 P.M., and on 1/8/24 at 10:30 A.M., with Resident 13. Resident 13 was observed having difficulty communicating, trying to say incomprehensible words, murmuring words, making sign language, nodding his head up and down or side to side. In addition, Resident 13 was also observed without a communication tool (a book or a board to convey a message). A review of Resident 13's Care Plan last revised on 11/17/23 indicated The resident has a communication problem r/t [related to] Dementia, CVA [Cerebrovascular Accident - sudden interruption of blood flow to brain] .Interventions/Tasks: .Use alternative communication tools as needed . A concurrent observation, interview and record review were conducted on 1/8/25 at 6:31 P.M., with Licensed Nurse (LN) 1. LN 1 stated Resident 13 did not have a communication tool to help him convey his message. LN 1 stated Resident 13's care plan indicated, The resident has a communication problem r/t [related to] Dementia, CVA [Cerebrovascular Accident - sudden interruption of blood flow to brain] .Interventions/Tasks: . Use alternative communication tools as needed . LN 1 acknowledged that Resident 13 did not have a communication tool to use that would help him convey his message to staff. An interview was conducted on 1/10/25 at 6 P.M., with the Director of Nursing (DON). The DON stated Resident 13 had difficulty expressing themselves and needed a communication tool. The DON acknowledged that Residents 13 should have had a communication tool but did not. The DON further stated the communication tool was important for Residents 13 to convey his message and needs to staff. A review of facility's policy and procedure titled, Care of Deaf or Hearing Impaired Resident dated 1/12/12 indicated, III Procedure for Communicating with the Resident: .D. If the resident is unable to hear, provide a pencil and paper to communicate in writing or a communication board if warranted . 2. Resident 36 was admitted to the facility on [DATE] with diagnosis which included aphasia (difficulty speaking) and hemiplegia (partial paralysis) per Resident 36's Admission Record. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations were conducted on 1/7/25 at 12:28 P.M. and on 1/8/24 at 10:45 A.M., with Resident 36. Resident 36 was observed having difficulty communicating and was making sign language, nodding his head up and down or side to side, and was making thumbs up. In addition, Resident 36 was also observed without a communication tool (a book or a board to convey a message). A review of Resident 36's Care Plan last revised on 7/3/23 indicated, The resident has a communication problem r/t [related to] Expressive Aphasia [difficulty expressing words and thought], Receptive Aphasia [difficulty to understand speech or symbol], Stroke [interruption of blood flow to brain causing damage to brain tissue] .Interventions/Tasks: .Use alternative communication tools as needed . A concurrent observation, interview and record review were conducted on 1/8/25 at 6:31 P.M., with Licensed Nurse (LN) 1. LN 1 stated Resident 36 did not have a communication tool to help him convey his message. LN 1 stated Resident 36's diagnoses included aphasia, and the care plan indicated The resident has a communication problem r/t [related to] expressive aphasia, receptive aphasia .Interventions/Tasks: .Use alternative communication tools as needed . LN 1 acknowledged that Resident 36 did not have a communication tool to help him convey his message to staff. An interview was conducted on 1/10/25 at 6 P.M., with the Director of Nursing (DON). The DON stated Resident 36 had difficulty expressing themselves and needed a communication tool. The DON acknowledged that Residents 36 should have had a communication tool but did not. The DON further stated the communication tool was important for Residents 36 to convey their message and needs to staff. A review of facility's policy and procedure titled, Care of Deaf or Hearing Impaired Resident dated 1/12/12 indicated, III Procedure for Communicating with the Resident: .D. If the resident is unable to hear, provide a pencil and paper to communicate in writing or a communication board if warranted .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45909 Based on observation, interview and record review, the facility failed to provide the needed care for one of three residents (Resident 54) when Resident 54's skin discoloration was not assessed and documented for monitoring. This failure had the potential for nursing staff to not identify any deterioration on Resident 54's skin discoloration which could result in delay of treatment. Findings: A review of Resident 54's face sheet indicated, Resident 54 was admitted to the facility on [DATE] with diagnoses that included dementia (forgetfulness), atrial fibrillation (A-Fib -irregular heart rate). A review of Resident 54's physician order dated 1/1/25, indicated, Resident 54 was receiving Apixaban (generic name, anticoagulant - blood thinner) oral tablet. Give 2.5 milligrams (mg - unit of measurement) by mouth two times a day for A-Fib. An initial tour conducted on 1/7/25 at 10:45 A.M., Resident 54 was observed to have a purplish discoloration on his right side of his right elbow. A concurrent interview and record review was conducted with the Director of Staff Development (DSD) on 1/9/25. The DSD stated, Resident 54's nursing care plan dated 8/1/23 indicated, Resident 54's bruising should be monitored and documented on Resident 54's treatment activity record (TAR- documentation where skin is monitored). The DSD stated, there was no documentation on Resident 54's TAR the right elbow discoloration was recorded for monitoring. The DSD further stated, Resident 54's skin discoloration should have been monitored and documented timely to address the care needed. An interview was conducted with the Director of Nursing (DON) on 1/10/25 at 9:30 A.M. The DON stated it was her expectation that nursing staff monitor and properly documented any skin changes on the residents TAR. The DON further stated, Resident 54's skin discoloration should have been documented and monitored by nursing staff to address changes but was not. Review of the facility's policy titled, Skin and Wound Management dated 2022, indicated. III. Documentation . C. New non pressure ulcers, bruises and lacerations will be documented on the 24 Hour Log and an incident report will be completed by the Licensed Nurse to determine casual factors contributing to the development of the skin condition.

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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** 45909 Based on observation, interview and record review, the facility failed to ensure a gastric tube (GT - tube surgically inserted inserted into the stomach to provide food and medication) was free from a possible complication for one of one resident (Resident 23) when Resident 23's GT had an air bubble (pocket of air trapped)in the line. This failure had the potential to compromise Resident 23's health condition. Finding: A review of Resident 23's face sheet indicated she was admitted to the facility on [DATE] with medical diagnoses of dysphagia (difficulty swallowing), cerebral infarction (blockage in the brain causing weakness), and hemiplegia (weakness in one part of the body). A review of Resident 23's Physician's History and Physical (PHP- physician assessment about a resident's health) dated 4/8/24 indicated, Resident 23 did not have the capacity to understand and make decisions on her own. A concurrent observation and interview were conducted with the Director of Staff Development (DSD) on 1/9/25 at 7:04 P.M. Resident 23's GT was observed to have air from the bottle down to the tubing near Resident 23's stomach. The DSD stated the licensed nurse who prepared the GT should have primed (run small amount of fluid) the tube. The DSD further stated Resident 23 and her GT should have been checked every two hours to monitor the GT feeding was free from air to prevent Resident 23 from experiencing possible abdominal discomfort. An interview was conducted with the Director of Nursing on 1/10/25 at 10:40 A.M. The DON stated, licensed nurses should have checked residents GT before, during and after infusion of GT feeding. The DON further stated Resident 21's GT should have been free from any air bubble that can cause complication. Review of the facility's policy titled, Enteral Feedings dated 9/7/23 indicated, .Prime pump tubing .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45909 Based on observation, interview and record review, the facility failed to replace an oxygen cylinder for one of three residents (Resident 61) in a timely manner. This failure had the potential for Resident 61 to run out of oxygen and affect her wellbeing. Finding: A review of Resident 61's face sheet indicated, Resident 61 was admitted to the facility on [DATE] with diagnoses that included heart failure, respiratory failure with hypoxia (low level of oxygen). A review of Resident 61's physician order dated 7/9/24 indicated, Oxygen at 2 liters per minute via nasal cannula every shift for shortness of breath (SOB). An initial observation and interview was conducted with Resident 61 on 1/7/25 at 11:43 A.M. Resident 61 stated, there was no oxygen coming out of her cannula. Resident 61 further stated she needed continuous oxygen. Resident 61's oxygen tank was observed empty. An interview was conducted with certified nursing assistant (CNA) 6 on 1/7/25 at 11:50 A.M. CNA 6 stated, Resident 61's oxygen tank was empty and needed to be replaced with a filled-up oxygen tank. An interview was conducted with the Director of Staff Development (DSD) on 1/9/25 at 9:35 A.M. The DSD stated, Resident 61 was dependent on oxygen and her oxygen tank should have been checked by nursing staff every two hours for fullness and functionality. An interview was conducted with the Director of Nursing (DON) on 1/10/25 at 10:00 A.M. The DON stated she expects the nursing staff to provide adequate oxygenation to residents. The DON further stated, Resident 61's oxygen tank should have been replaced timely with a full oxygen tank to prevent Resident 61 from having SOB. Review of the facility's policy titled, Oxygen Therapy dated, 11/2017, indicated, Procedure. I. Administer oxygen per physician orders .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43674 Based on observation, interview and record review, the facility failed to ensure Licensed Nurse followed the physician order and had adequate competency in providing care to: 1. 4 of 18 (Resident 2, Resident 13, Resident 23, and Resident 52) sampled residents with low air loss mattress (mattress that uses air to relieve pressure). 2. 2 of 19 (Resident 2 and Resident 72) sampled residents with wound vacuum (wound vac - a device that uses negative pressure to help wounds heal). This failure had the potential risk to resident's care and well-being. Findings: 1a. Resident 2 was admitted to the facility on [DATE] with diagnoses which included hemiplegia (paralysis of one side of the body), diabetes (high blood sugar) and pressure ulcer (wound) per Resident 2's undated Admission Record. A review of Residents 2's physician orders indicated the low air loss mattress order: Low air loss mattress . settings are based on weight, may adjust for comfort . A concurrent observation, interview and record review was conducted on 1/9/25 at 5:30 P.M., with Licensed Nurse (LN) 4. Resident 2 was observed with a low air loss mattress and setting was at 120. LN 4 stated Resident 2's weight on 1/4/25 was 120.6 lbs. LN 4 stated she did not know about the low air loss mattress's manufacturer's guideline and how to set low air loss mattress according to weight per manufacturer's guideline. LN 4 further stated she did not receive a competency on the 3 different low air loss mattress and pump used in the facility. An interview was conducted on 1/10/25 at 6 P.M., with the Director of Nursing (DON). The DON stated she was not aware of the different kinds of low air loss mattress and pumps that were used in the facility. The DON stated she did not know about the low air loss mattress and pump manufacturer's guideline and the competency and training of the facility staff. The DON acknowledged that facility staff should be aware of the manufacturer's guideline of low air loss mattress and should have training and competency, but did not have. The DON further stated it was important to have the training and competency of the equipment low air loss mattress to ensure patient safety and maximum benefit as indicated by the physician order. A review of facility's policy and procedure titled, Mattress Resource (undated) indicated, .3. Air Mattress (Low Air Loss) .E. Follow manufacturer's guidelines to ensure appropriate settings . 1b. Resident 13 was admitted to the facility on [DATE] with diagnoses which included dementia (a decline in mental abilities that affects thinking, memory, and behavior), hemiplegia (paralysis of one side of the body), and urinary retention (unable to empty urine in bladder) per Resident 13's undated Admission Record. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Residents 13's physician orders indicated the low air loss mattress order: Low air loss mattress . settings are based on weight, may adjust for comfort . A concurrent observation, interview and record review was conducted on 1/9/25 at 5:30 P.M., with Licensed Nurse (LN) 4. Resident 13 was observed with a low air loss mattress and setting was at 210. LN 4 stated Resident 13's weight on 1/1/25 was 129.6 lbs. LN 4 stated she did not know about the low air loss mattress's manufacturer's guideline and how to set low air loss mattress according to weight per manufacturer's guideline. LN 4 further stated she did not receive a competency on the 3 different low air loss mattress and pump used in the facility. An interview was conducted on 1/10/25 at 6 P.M., with the Director of Nursing (DON). The DON stated she was not aware of the different kinds of low air loss mattress and pumps that were used in the facility. The DON stated she did not know about the low air loss mattress and pump manufacturer's guideline and the competency and training of the facility staff. The DON acknowledged that facility staff should be aware of the manufacturer's guideline of low air loss mattress and should have training and competency,but did not have. The DON further stated it was important to have the training and competency of the equipment low air loss mattress to ensure patient safety and maximum benefit as indicated by the physician order. A review of facility's policy and procedure titled, Mattress Resource (undated) indicated, .3. Air Mattress (Low Air Loss) .E. Follow manufacturer's guidelines to ensure appropriate settings . 1c. Resident 23 was admitted to the facility on [DATE] with diagnoses which included hemiplegia (paralysis of one side of the body), diabetes (high blood sugar) per Resident 23's undated Admission Record. A review of Residents 23's physician orders indicated the low air loss mattress order: Low air loss mattress . settings are based on weight, may adjust for comfort . A concurrent observation, interview and record review was conducted on 1/9/25 at 5:30 P.M., with Licensed Nurse (LN) 4. Resident 23 was observed with a low air loss mattress and setting was at 150. LN 4 stated Resident 23's weight on 1/1/25 was 160 lbs. LN 4 stated she did not know about the low air loss mattress's manufacturer's guideline and how to set low air loss mattress according to weight per manufacturer's guideline. LN 4 further stated she did not receive a competency on the 3 different low air loss mattress and pump used in the facility. An interview was conducted on 1/10/25 at 6 P.M., with the Director of Nursing (DON). The DON stated she was not aware of the different kinds of low air loss mattress and pumps that were used in the facility. The DON stated she did not know about the low air loss mattress and pump manufacturer's guideline and the competency and training of the facility staff. The DON acknowledged that facility staff should be aware of the manufacturer's guideline of low air loss mattress and should have training and competency, but did not have. The DON further stated it was important to have the training and competency of the equipment low air loss mattress to ensure patient safety and maximum benefit as indicated by the physician order. A review of facility's policy and procedure titled, Mattress Resource (undated) indicated, .3. Air Mattress (Low Air Loss) .E. Follow manufacturer's guidelines to ensure appropriate settings . (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1d. Resident 52 was admitted to the facility on [DATE] with diagnoses which included neoplasm of spinal cord (tumor around the spinal cord) and paraplegia (paralysis of the lower body) per Resident 52's undated Admission Record. A review of Residents 52's physician orders indicated the low air loss mattress order: Low air loss mattress . settings are based on weight, may adjust for comfort . A concurrent observation, interview and record review was conducted on 1/9/25 at 5:30 P.M. with Licensed Nurse (LN) 4. Resident 52 was observed with a low air loss mattress and setting was at #3. LN 4 stated Resident 23's weight on 1/1/25 was 112.8 lbs. LN 4 stated she did not know about the low air loss mattress's manufacturer's guideline and how to set low air loss mattress according to weight per manufacturer's guideline. LN 4 further stated she did not receive a competency on the 3 different low air loss mattress and pump used in the facility. An interview was conducted on 1/10/25 at 6 P.M., with the Director of Nursing (DON). The DON stated she was not aware of the different kinds of low air loss mattress and pumps that were used in the facility. The DON stated she did not know about the low air loss mattress and pump manufacturer's guideline and the competency and training of the facility staff. The DON acknowledged that facility staff should be aware of the manufacturer's guideline of low air loss mattress and should have training and competency, but did not have. The DON further stated it was important to have the training and competency of the equipment low air loss mattress to ensure patient safety and maximum benefit as indicated by the physician order. A review of facility's policy and procedure titled, Mattress Resource (undated) indicated, .3. Air Mattress (Low Air Loss) .E. Follow manufacturer's guidelines to ensure appropriate settings . 2a. Resident 2 was admitted to the facility on [DATE] with diagnoses which included hemiplegia (paralysis of one side of the body), diabetes (high blood sugar) and pressure ulcer (wound) per Resident 2's undated Admission Record. A review of Resident 2's physician order dated 12/25/24 indicated, KCI Negative Wound Vac therapy device to be placed to Right Buttock stage 4 pressure injury and changed Wednesday and Saturdays. every day shift every Mon, Thu for stage 4 pressure injury for 21 days cleanse with Dakin's solution, pat dry, apply wound vac and change on specific days. A concurrent interview and record review was conducted on 1/9/25 at 6:15 P.M., with Licensed Nurse (LN) 4. LN 4 stated Resident 2 was on wound vac therapy was set with a negative pressure of 125 mm/Hg (Millimeters of mercury - a unit that measures the pressure). LN 4 stated Resident 2's physician order dated 12/25/24 was incomplete and should have been clarified with the physician. LN 4 stated, the nursing staff did not clarify the order and set the negative pressure setting of the wound vac to 125 mm/Hg. An interview was conducted on 1/10/24 at 6 P.M. with the Director of Nursing (DON). The DON stated the physician order on wound vac therapy was incomplete without the negative pressure settings and should have been clarified by the nursing staff. The DON further stated it was important to ensure physician orders were clear and complete to ensure physician orders were carried out as ordered for patient's safety. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility's policy and procedure titled, Physician Orders last revised 11/16/22 indicated, .Policy: The licensed nurse will confirm that physician orders are clear, complete and accurate as needed . 2b. Resident 72 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus (high blood sugar) and chronic ulcer (wound) of right foot per Resident 72's undated Admission Records. A review of Resident 72's physician order dated 12/18/24 indicated, KCI negative Wound Vacc [sic] therapy device to be placed to Right Dorsal foot x Surgical wound to be changed on Wednesday and Saturday. Every day shift every Wed, Sat for surgical wound for 21 Days. Cleanse with Dakin's Solution, pat dry, apply wound vacc [sic] on specific days. A concurrent interview and record review was conducted on 1/9/25 at 6:15 P.M., with Licensed Nurse (LN) 4. LN 4 stated Resident 72 was on wound vac therapy was set with a negative pressure of 125 mm/Hg (Millimeters of mercury - a unit that measures the pressure). LN 4 stated Resident 72's physician order dated 12/18/24 was incomplete and should have been clarified with the physician. LN 4 stated, the nursing staff did not clarify the order and set the negative pressure setting of the wound vac to 125 mm/Hg. An interview was conducted on 1/10/24 at 6 P.M. with the Director of Nursing (DON). The DON stated the physician order on wound vac therapy was incomplete without the negative pressure settings and should have been clarified by the nursing staff. The DON further stated it was important to ensure physician orders were clear and complete to ensure physician orders were carried out as ordered for patient's safety. A review of facility's policy and procedure titled, Physician Orders last revised 11/16/22 indicated, .Policy: The licensed nurse will confirm that physician orders are clear, complete and accurate as needed .

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 45909 Based on interview and record review, the facility failed to provide a registered nurse (RN) for at least eight hours a day to 99 residents. This failure had the potential to affect residents care, health, and wellbeing. Findings: Review of the Centers for Medicare and Medicaid Services (CMS - federal agency responsible in implementing standards in the long-term care facilities) Payroll Based Journal (PBJ - system where staffing information are collected on a regular basis) for the quarter 4 2024 (July 1 - September 30) indicated, No RN hours four or more days. A concurrent interview and record review was conducted with the Director of Staff Development (DSD) on 1/9/25 at 12:45 P.M. The DSD reviewed the facility's daily assignment sheets dated, 7/13/24, 7/20/24, 8/10/24, 8/24/24 and 9/15/24. The DSD stated, there was no RN coverage for at least eight hours a day from July to September 2024. The DSD further stated, an RN should have been in the facility to provide RN care when needed. An interview was conducted with the Director of Nursing on 1/10/25 at 10:07 A.M. The DON stated, a RN should have been in the facility for at least eighth hours per day to provide residents with the necessary and appropriate RN care when needed. Review of the facility's policy titled, Nursing Department - Staffing, Scheduling and Postings revised 7/2018, indicated, .Procedure 1. Nurse Staffing .B. If the facility is licensed for 60 - 99 beds, it will have the following: i. At least one Registered Nurse or Licensed Vocational Nurse, in the facility at all times, day and night, in addition to the Director of Nursing Services (DONS).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43674 Based on observation, interview and record review, the facility failed to ensure administration of medication were implemented per physician orders to 2 of 18 sampled residents. This failure had the potential risk to the residents' well-being and care. Findings: 1. Resident 2 was admitted to the facility on [DATE] with diagnoses which included hemiplegia (paralysis of one side of the body), diabetes (high blood sugar) and pressure ulcer (wound) per undated Admission Record. A review of Resident 2's physician orders indicated the medication order Humalog Injection Solution 100 UNIT/ML (Insulin Lispro) inject as per sliding scale: if 0[noted possible typo 70}-150=0; 151-200=3; 201-250=5; 251-300=8; 301-350=12; 351-400=15, subcutaneous [under the skin] before meals and at bedtime for diabetes > 400 notify MD [medical doctor] if BS [blood sugar] below 70 and follow hypoglycemic protocol [management/treatment of low blood sugar] A review of facility's meal service times indicated, Breakfast: Rooms at 7:30 A.M. and Dining Room at 7:45 A.M.; Lunch: Dining Room at 11:15 A.M, and Rooms at 11:30 A.M.; Dinner: Dining Rooms at 5:15 P.M., and Rooms at 5:30 P.M. A review of Resident 2's Medication Administration Record (MAR) indicated blood sugar check and Humalog (Insulin Lispro) administration on 1/7/25 before lunch at 2:46 P.M., on 1/8/25 before breakfast at 11:46 A.M., and before dinner at 6:09 P.M. A concurrent interview and record review of Resident 2's Medication Administration Record (MAR) was conducted on 1/10/25 at 2:30 P.M. with Licensed Nurse (LN) 1. LN 1 stated Humalog administration were scheduled before breakfast at 7 A.M., before lunch at 12 P.M., and before dinner at 5 P.M. LN 1 stated Resident 2's MAR indicated that Blood sugar check and Humalog (Insulin Lispro) administration were not done before scheduled meals and within 1 hour of scheduled medication administration on 1/7 and 1/8/25. An interview was conducted on 10/10/25 at 5:44 P.M., with LN 1. LN 1 stated the physician order on Humalog (Insulin Lispro) was ordered and timed before meals. LN 1 stated Resident 2's physician order for Humalog was not followed and administered per Resident 2's MAR documentation. LN 1 stated the MAR indicated the Humalog physician order was completed after scheduled meals and were off the scheduled administration schedule. An interview was conducted on 1/10/25 at 6 P.M., with the Director of Nursing (DON). The DON acknowledged that Resident 2's Humalog (Insulin Lispro) administration time was not and should have been implemented before meals as ordered by physician. The DON stated it was important that Insulin medications should be administered timely to prevent adverse effect on the over-all health of the resident. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility's policy and procedure titled, Medication-Administration last revised 1/1/12 indicated, . Policy: Medication will be administered directed by a Licensed Nurse and upon the order of a physician or licensed independent practitioner . 2. Resident 65 was admitted to the facility on [DATE] with diagnoses which included hemiplegia (paralysis of one side of the body), diabetes (high blood sugar) per undated Admission Record. A review of Resident 65's physician orders indicated the medication order Humalog Injection Solution 100 UNIT/ML (Insulin Lispro) inject as per sliding scale: if 70-150=0; 151-200=3; 201-250=5; 251-300=8; 301-350=12; 351-400=15, subcutaneous [under the skin] before meals and at bedtime for dm [diabetes mellitus]. A review of facility's meal service times indicated Breakfast: Rooms at 7:30 A.M. and Dining Room at 7:45 A. M.; Lunch: Dining Room at 11:15 A.M and Rooms at 11:30 A.M.; Dinner: Dining Rooms at 5:15 P.M. and Rooms at 5:30 P.M. A review of Resident 65's Medication Administration Record (MAR) indicated blood sugar check and Humalog (Insulin Lispro) administration on 1/6/25 before lunch at 12:02 P.M, 1/7/25 before lunch at 1:54 P.M. , before dinner at 6:01 P.M., on 1/8/25 before breakfast at 9:25 A.M., and before dinner at 5:47 P.M. A concurrent interview and record review of Resident 65's MAR was conducted on 1/10/25 at 2:30 P.M., with Licensed Nurse (LN) 1. LN 1 stated Humalog administration were scheduled before breakfast at 7 A.M., before lunch at 11 A.M., and before dinner at 4 P.M. LN 1 stated Resident 65's MAR indicated that Blood sugar check and Humalog (Insulin Lispro) administration were not done before scheduled meals and within 1 hour of scheduled medication administration on 1/6, 1/7 and 1/8/25. An interview was conducted on 10/10/25 at 5:44 P.M., with LN 1. LN 1 stated the physician order on Humalog (Insulin Lispro) was ordered and timed before meals. LN 1 stated Resident 65's physician order for Humalog was not followed and administered per Resident 65's MAR documentation. LN 1 stated the MAR indicated the Humalog physician order was completed after scheduled meals and were off the scheduled administration schedule. An interview was conducted on 1/10/25 at 6 P.M., with the Director of Nursing (DON). The DON acknowledged that Resident 65's Humalog (Insulin Lispro) administration time was not and should have been implemented before meals as ordered by physician. The DON stated it was important that Insulin medications should be administered timely to prevent adverse effect on the over-all health of the resident. A review of facility's policy and procedure titled, Medication-Administration last revised 1/1/12 indicated, . Policy: Medication will be administered directed by a Licensed Nurse and upon the order of a physician or licensed independent practitioner .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43674 Based on observation, interview, and record review, the facility failed to ensure medication error rate for medication pass did not exceed 5 percent. There were 25 medication opportunities. Four medication errors were identified. The error rate was 16%. This failure had the potential to cause harm to the residents. Findings: 1. Resident 38 was admitted to the facility on [DATE] with diagnoses which included diabetes (high blood sugar), peripheral vascular disease (PVD - circulatory condition when blood vessels narrow, spasm, or become blocked) and foot ulcer (wound) per undated Admission Record. A review of Resident 38's physician orders indicated the following medication orders: 1. Carvedilol oral tablet 3.125 MG (Carvedilol). Give 1 tablet by mouth every 12 hours for HTN. Hold SBP >90 or DBP <60; 2. Ticagrelor Oral Tablet 90 MG (Ticagrelor). Give 1 tablet by mouth two times a day for antiplatelet; 3. Hydrocodone-Acetaminophen Oral Tablet 10-325 MG (Hydrocodone-Acetaminophen). Give 1 tablet by mouth every 6 hours as need for pain (Severe 7-10). A medication pass observation was conducted on 1/9/25 at 7:50 P.M., with Licensed Nurse (LN) 2. LN 2 prepared Resident 38's 3 medications that included Carvedilol 3.125 MG 1 tablet, Ticagrelor 90 MG 1 tablet and Hydrocodone-Acetaminophen 10-325 MG 1 tablet. LN 2 approached Resident 38 and administered the 3 medications. LN 2 did not identify the Resident 38 with 2 identifiers prior to medication administration. An interview was conducted on 1/9/25 at 8 P.M., with LN 2. LN 2 stated he did not check for resident identifier prior to the administration of the 3 medications. LN 2 stated he should have checked for the resident identifier before administering the medications even though he was familiar with the resident. LN 2 further stated it was important to ensure residents were properly identified during medication administration for the safety of the residents. An interview was conducted on 1/10/25 at 6 P.M., with the Director of Nursing (DON). The DON stated it was important to follow the identification process of residents during medication pass. The DON further stated identifying the right resident would prevent medication errors by not giving any medications to wrong residents. The DON acknowledged that during medication pass, residents should be identified per policy to ensure the safety of the residents. A review of facility's policy and procedure titled, Medication-Administration last revised 1/1/12 indicated, Purpose: To ensure the accurate administration of medications for residents in the Facility .Procedure: I. Administration of Medications: .D. Medications must be given to the resident by the Licensed Nurse preparing the medication. i. The licensed Nurse will verify the resident's identity before administering the medication . (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident 13 was admitted to the facility on [DATE] with diagnoses which included dementia (a decline in mental abilities that affects thinking, memory, and behavior), hemiplegia (paralysis of one side of the body), and urinary retention (unable to empty urine in bladder) per Resident 13's Admission Record. A review of Resident 13's physician order indicated the medication order: Artificial Tears Solution 1% (Carboxymethylcellulose Sodium). Instill 1 drop in both eyes three times a day for DM eyes. A medication pass was conducted on 1/10/25 at 3:11 P.M. with LN 3. LN 3 prepared Resident 13's medication that included Artificial Tear Solution 1%. LN 3 approached Resident 13 and administered the medication. LN 3 did not identify Resident 13 with 2 identifiers prior to medication administration. An interview was conducted on 1/10/25 at 3:15 P.M. with LN 3. LN 3 stated she did not identify the resident by asking for 2 identifiers. LN 3 stated she identified Resident 13 by calling for his name and was familiar with the resident. LN 3 stated she should have used the identifiers per policy to prevent medication administration error. An interview was conducted on 1/10/25 at 6 P.M., with the Director of Nursing (DON). The DON stated it was important to follow the identification process of residents during medication pass. The DON further stated identifying the right resident would prevent medication errors by not giving any medications to wrong residents. The DON acknowledged that during medication pass, residents should be identified per policy to ensure the safety of the residents. A review of facility's policy and procedure titled, Medication-Administration last revised 1/1/12 indicated, Purpose: To ensure the accurate administration of medications for residents in the Facility .Procedure: I. Administration of Medications: .D. Medications must be given to the resident by the Licensed Nurse preparing the medication. i. The licensed Nurse will verify the resident's identity before administering the medication .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45909 Based on observation, interview and record review, the facility failed to store foods under sanitary conditions when eight loaves of bread with use by labels (date when food should be consumed) were not discarded. This failure had the potential to cause food contamination and spread food-borne illness (illness resulting from contaminated food) in a population of 72 residents. Findings: During a tour of the kitchen with the Dietary Supervisor (DS) on 1/7/25 at 10:04 A.M., Eight loaves of bread were observed labeled with a use by date of 1/6/25. During an interview with the DS on 1/10/25 at 10:15 A.M., the DS stated the eight loaves of bread labeled with use by 1/6/25 should have been discarded either a day before the use by date or on the day of use by. The DS further stated, facility residents may get affected with food borne illness when they consume food pass the use by date. During an interview with the Registered Dietitian (RD) on 1/10/25 at 10:20 A.M. The RD stated bread with use by labels should be thrown away a day or on the day of the use by date. The RD further stated, the eight loaves of bread observed on 1/7/25 should have been discarded on either 1/5/25 or 1/6/25. Review of the Food and Drug Administration (FDA - a US government agency that ensures safety of food) 2022 indicated, 3-501.18 Ready to Eat, Disposition (A) A food shall be discarded if it . (3) Is inappropriately marked with a date or exceeds a temperature and time

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45063 Based on observation, interview and record review, the facility failed to ensure infection control procedures were maintained in the facility when: 1) A water reservoir tank was observed to be leaking and with greenish black substance. 2) A suprapubic catheter (a tube inserted into the bladder through a cut in the tummy to drain urine from the bladder) bag and dignity bag (a bag used to cover and conceal contents inside), was lying on the floor for one of three residents reviewed for urinary catheter care (Resident 13). These failures had the potential for the spread of infection. Findings : 1) On 1/10/25 at 9:20 A.M., a tour of the facility with the Infection Preventionist (IP) was conducted. A 550-gallon water reservoir tank was observed just outside the kitchen. The water reservoir tank was observed to be with water leaking and with greenish black substance surrounding the opening of the faucet. The opening of the faucet was not covered. On 1/10/25 at 9:25 A.M., an interview with IP was conducted. IP stated the water reservoir tank should had been regularly inspected and checked for leaking but were not done. IP acknowledged the greenish black substance surrounding the opening of the faucet were molds. IP stated the water inside the water reservoir is not usable and it's an infection control issue. On 1/10/25 at 9:35 A.M., an interview with the Maintenance Supervisor (MS) was conducted. MS stated he should have checked the water reservoir tank for leaking and molds, but was not able to. MS stated leaking water can cause molds and its an infection control issue . On 1/10/25 at 5:30 PM , an interview with the Director of Nursing (DON) was conducted. DON stated the water reservoir tank should had been regularly inspected for water leaking and molds. DON acknowledged water leaks and molds are a potential cause of water borne pathogens and infections. Per the facility's policy and procedure (P&P) titled, Water management Program, Infection Control Manual revised June 2017, the P&P indicated, Policy . The facility will develop and maintain a water management program to reduce .and other waterborne pathogen growth and potential spread in the facility . 43674 2. Resident 13 was admitted to the facility on [DATE] with diagnoses which included dementia (a decline in mental abilities that affects thinking, memory, and behavior), hemiplegia (paralysis of one side of the body), and urinary retention (unable to empty urine in bladder) per Resident 13's Admission Record. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation was conducted on 1/9/25 at 9:18 A.M., with Resident 13. Resident 13 was observed on a wheelchair in the hallway. Resident 13 had a urinary catheter bag attached to a wheelchair and was touching the floor. A concurrent observation and interview were conducted on 1/9/25 at 9:21 A.M., with the Director of Nursing (DON). The DON stated Resident 13's urinary catheter bag was touching the floor. The DON further stated it was important that the urinary catheter bag does not touch the floor to prevent contamination and the spread of infection. A review of facility's policy and procedure titled, Care of Catheter last revised 6/10/21 indicated, Procedure: . IV Catheter Insertion: .D. The catheter and collecting bag or spigot will be anchored to not touch the floor .

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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** 45063 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. Finding: On 1/7/25 through 1/10/25, 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), with CMS Certification Number: 555557, 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 by CMS Certification Number: 555557 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** 45063 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 1/7/25 through 1/10/25, 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 five 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), with CMS Certification Number: 555557, 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 CMS Certification Number: 555557 letter to the facility from CMS.