STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555686	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Studio City Rehabilitation Center	11429 Ventura Blvd Studio City, CA 91604

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44244 Based on observation, interview, and record review the facility failed to provide reasonable accommodation of resident needs and preferences by failing to ensure the call light (an alerting device for nurses or other nursing personnel to assist a resident when in need) was within reach for one of three residents (Resident 35 and 144) reviewed during the Environment task and for two of four sampled residents (Residents 104 and 134) observed during a random observation. This deficient practice had the potential to result in the delay of care and services and possible injury to residents when they are unable to ask assistance from facility staff. Findings: a.During a review of Resident 35's Admission Record, the Admission Record indicated the facility admitted the resident on 6/22/2024 with diagnoses that included cerebral infarction (stroke, when blood flow to the brain is blocked or there is sudden bleeding in the brain), unspecified abnormalities of gait (manner of walking) and mobility, muscle weakness, and encephalopathy (a change in your brain function due to injury or disease). During a review of Resident 35's Minimum Data Set (MDS - an assessment and care screening tool) dated 6/29/2024, the MDS indicated the resident rarely/never was able to understand others and rarely/never was able to make herself understood. The MDS indicated the resident was dependent on staff for oral hygiene, toileting, bathing, dressing, personal hygiene, and mobility. During a review of Resident 35's Fall Risk Assessment form, dated 6/22/2024, the form indicated the resident was a high risk for falls with intermittent confusion or poor safety awareness. During a review of Resident 35's Physician Orders Summary Report, the report indicated an order for the Falling Star Program with frequent visual monitoring due to high risk for fall and injury, every shift, dated 6/22/2024. During a review of Resident 35's Care Plan (CP) titled, Resident is at risk for falls/injury . initiated 7/9/2024, the CP indicated to keep the call light within easy reach and encourage resident to use it to get assistance. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 8/20/2024 at 10:17 a.m., observed Resident 35 lying in bed with the bed in low position and fall mat on the floor. Observed the call light resting on the floor at the left side of the bed. The call light was visible from the door and foot of the bed. Observed Certified Nursing Assistant 4 (CNA 4) enter Resident 35's room, look at the resident, and walked to the right side of the resident's bed. Observe CNA 4 then walk past the foot of the Resident's bed, look at the resident, and exit the room. Observed the call light remained on the floor. During a concurrent observation and interview on 8/20/2024 at 10:28 a.m., observed Restorative Nursing Assistant 3 (RNA 3) enter Resident 35's room. RNA 3 stated the call light was on the floor and should have been closer to the resident. RNA 3 stated the call light should have been on the resident's bed and within reach of the resident to make sure the resident had access to it. RNA 3 stated if the call light was not within reach anything could happen. During a follow up interview on 8/22/2024 at 10:32 a.m., with CNA 4, CNA 4 stated the call light should always be within reach of residents and she (CNA 4) did not see that Resident 35's call light was on the floor. During an interview on 8/22/2024 at 12:03 p.m., with Licensed Vocational Nurse 8 (LVN 8), LVN 8 stated she was caring for Resident 35 and every time the CNA enters the room the resident's environment should be checked, including the placement of the call light. LVN 8 stated if the call light is not within reach, staff would not know if the resident needed assistance. LVN 8 stated when residents are unable to call for assistance there is a potential for falls. During an interview on 8/23/2024 at 7:10 p.m., with the Director of Nursing (DON), the DON stated there is a potential risk for falls when the resident's call light is out of reach and staff are not aware that the resident needs assistance. During a review of the facility policy and procedure (P&P) titled, Call Lights, last reviewed 4/17/2024, the P&P indicated the purpose of the policy was to assure residents receive prompt assistance. Nursing and care duties include to ensure that the call light is within the resident's reach when in his/her room. 44376 b. During a review of Resident 144's Admission Record, the Admission Record indicated the facility admitted the resident on 1/22/2024, and readmitted the resident on 5/14/2024, with diagnoses including traumatic subdural hemorrhage (a serious condition that occurs when blood collects between the skull and the surface of the brain) and history of traumatic fracture (occurs when significant or extreme force is applied to a bone). During a review of Resident 144's History and Physical (H&P), dated 5/14/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 144's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 7/29/2024, the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired vision. The MDS indicated the resident was dependent on mobility and activities of daily living (ADLs, all the essential, basic self-care tasks that people need to do every day to keep themselves safe, healthy, clean, and feeling good). (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 144's Order Summary Report, dated 7/10/2024, the report indicated an order for frequent visual monitoring due to high risk for fall and injury. Document every shift. During a review of Resident 144's Fall Risk Assessment, dated 7/25/2024, the assessment indicated the resident was high risk for falls. During a review of Resident 144's Care Plan (CP) titled, Resident is at risk for falls/injury related to generalized weakness, impaired cognition (problems with a person's ability to think, learn, remember, use judgement, and make decisions), impaired vision, poor body balance/control, poor safety awareness/judgement, initiated on 1/31/2024, the CP indicated an intervention to keep call light within easy reach and encourage resident to use it to get assistance. During a concurrent observation and interview on 8/20/2024, at 10:43 a.m., with Certified Nursing Assistant 3 (CNA 3), inside Resident 144's room, observed Resident 4 lying in bed. The resident's pad call light placed on top of the bed side drawer away from the resident's reach. CNA 3 stated the call light should be within reach of the resident so the resident can call for help when needed. During an interview on 8/23/2024, at 7:10 p.m., with the DON, the DON stated the pad call light should be near the resident's body so they can have access to call the staff. The DON stated not having the pad call light within reach of the resident could result in the resident not being able to call for help and could possibly fall trying to reach for the pad call light. During a review of the facility's recent policy and procedure P&P) titled, Call Lights, last revised on 4/17/2024, the P&P indicated to assure resident receive prompt assistance. Ensuring that the call light is within the resident's reach when in his/her room or when on the toilet. 43988 c. During a review of Resident 104' Admission Record, the Admission Record indicated the facility admitted the resident on 8/24/2020 and readmitted in the facility 3/14/2024 with diagnoses including but not limited to chronic respiratory failure (a long-term condition in which your lungs have a hard time loading your blood with oxygen and can leave you with low oxygen), paraplegia (refers to total paralysis on both sides of the body), and anoxic brain damage (a condition that refers to an injury to the brain due to complete loss of oxygen). During a review of Resident 104's History and Physical dated 3/15/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 104's MDS, dated [DATE], the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 104 had impairment on both upper and lower extremities. During a review of Resident 134's Fall Risk Assessments dated 3/14/2024, 5/6/2024, and 7/29/2024, the assessments indicated the resident was a high risk for falls. During a review of Resident 104's care plan (CP), the CP indicated the following: (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1.Resident is at risk for falls/injury related but not limited to history of falls, impaired cognition, impaired vision, poor body balance/ control, poor safety awareness/judgment, and collapse initiated 8/26/2020 target date 11/2/2024 indicated a goal to reduce risk of falls and injury. The care plan indicated to keep call light within easy reach and encourage resident to use it to get assistance as on the interventions. 2. At risk for falls related but not limited to cognitive impairment, decreased strength/endurance, unsteady gait, and visual deficits initiated 7/10/2024 target date 11/2/2024 indicated a goal to reduce risk of falls and/or injury thru appropriate intervention(s) daily until the next assessment. The care plan indicated to attach call light to bed within access of resident as one of the interventions. During a concurrent observation, and interview on 8/20/2024 at 1:20 p.m. with Licensed Vocational Nurse 4 (LVN 4) inside Resident 104's room, observed the resident lying in bed facing the left side. Observed Resident 104's call light on top of the left uppermost side of the bed and away from resident's reach. LVN verified the pad call light was not within the resident's reach. LVN 4 stated Resident 104 is at risk for falls or injury when the resident cannot use the pad call light to call for assistance to meet the resident's needs. During an interview on 8/23/2024 at 7:10 p.m., the DON, the DON stated the pad call light is sensitive and should be placed adjacent to any part of the resident's body so the resident can use it to call for assistance. The DON stated the pad call light will not activate if it is not close to the resident's body. During a review of the facility's policy and procedure (P&P) titled, Call Lights, last reviewed 4/17/2024, the P&P indicated to ensure residents receive prompt assistance by ensuring the call light is within the resident's reach when in his/her room or when on the toilet. d. During a review of Resident 134' Admission Record, the Admission Record indicated the facility admitted the resident on 3/4/2023 with diagnoses including but not limited to respiratory failure (a serious condition that makes it difficult to breathe on your own), encounter for tracheostomy (a surgical procedure to create an opening through the neck into the windpipe to facilitate breathing), and traumatic brain injury (a condition that occurs when a sudden trauma, such as a blow or jolt to the head, causes damage to the brain) with loss of consciousness. During a review of Resident 134's History and Physical (H&P) dated 3/6/2024, the H&P indicated the resident was incapacitated (incapable of normal functioning). During a review of Resident 134's MDS, dated [DATE], the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 134 had impairment on both upper and lower extremities. During a review of Resident 134's Fall Risk Assessments dated 12/11/2023, 3/9/2024, and 6/8/2024, the assessments indicated the resident was a high risk for falls. During a review of Resident 134's care plan (CP), the CP indicated: (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1.Resident is at risk for falls/injury related to fracture, generalized weakness, impaired cognition, impaired vision, poor body balance/ control, poor safety awareness/judgment, involuntary movements, spontaneous movements, resident requiring total care, resident requiring turning and repositioning initiated 3/8/2023 target date 9/9/2024 indicated a goal to reduce risk of falls and injury daily. The care plan indicated to keep call light within easy reach and encourage resident to use it to get assistance as one of the interventions. 2. Falling Star Program (a patient assessment program that identifies residents who are at high risk for falling). At risk for falls related but not limited to cognitive impairment, decreased strength/endurance, and history of falls initiated 7/10/2024 target date 9/9/2024 indicate a goal to reduce risk of falls and/or injury thru appropriate intervention(s) daily until the next assessment. The care plan indicated to attach call light to bed within access of resident. During a concurrent observation and interview on 8/20/2024 at 2:41 p.m. with Licensed Vocational Nurse 4 (LVN 4) inside Resident 134's room, observed the resident lying in bed facing the right side. Observed Resident 134's call light placed on top of the bedside table on the right side of the bed, next to the suction machine. LVN 4 verified the pad call light was not within the resident's reach. LVN 4 stated the resident moves a lot in bed and is at risk for falls or injury when the resident cannot use the call light to call for assistance to meet the resident's needs. During an interview on 8/23/2024 at 7:10 p.m., the DON, the DON stated the pad call light is sensitive and should be placed adjacent to any part of the resident's body so the resident can use it to call for assistance. The DON stated the pad call light will not activate if it is not close to the resident's body. During a review of the facility's policy and procedure (P&P) titled, Call Lights, last reviewed 4/17/2024, the P&P indicated to ensure residents receive prompt assistance by ensuring the call light is within the resident's reach when in his/her room or when on the toilet.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43418 Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity including the right to be free from physical restraints (any manual method, physical or mechanical device, equipment, or material that is attached or adjacent to the resident's body, cannot be removed easily by the resident, and restricts the resident's freedom of movement or normal access to his/her body) for four of six sampled residents (Resident 6,126, 9, and 467) investigated during review of the physical restraints care area and one of one sampled resident (Resident 30) investigated during random observation when the facility failed to: 1. Obtain a physician's order, obtain an informed consent from the resident or resident representative, and perform a restraint use assessment for use of left-and-right hand mitten (a large, soft glove that covers a resident's hand to prevent them from inadvertently dislodging medical equipment) restraints timely for Resident 6. 2. Obtain a physician's order, obtain an informed consent from the resident or resident representative, and perform an assessment prior to placing Resident 126's bed against the wall as a restraint 3. Obtain a physician's order, obtain an informed consent from the resident or resident representative, and perform an assessment prior to placing Resident 9's bed against the wall as a restraint. 4. Obtain a physician's order, obtain an informed consent from the resident or representative, and perform an assessment prior to use of four bed rails up for Resident 467. 5. Obtain a physician's order, informed consent, and perform an assessment prior to use of pillows tucked under fitted sheets bilaterally (both sides) for Resident 30. These deficient practices had the potential for residents and their representatives to be unaware of the risks and benefits for use of restraints and may result in the restriction of residents' freedom of movement, a decline in physical functioning, psychosocial harm, physical harm from entrapment (a state in which a person is trapped by the bed rail in a position that they cannot move from), death of residents, and violate the resident's rights to be free from any restraints that are imposed for reasons other than the treatment of the resident's medical symptoms. Cross-reference F656. Findings: 1. During a review of Resident 6's Admission Record, the Admission Record indicated the facility originally admitted Resident 6 on 11/28/2007 and readmitted the resident on 4/11/2024 with diagnoses including, but not limited to, attention for gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food via a tube). (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 6's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 6/21/2024, the MDS indicated Resident 6 was rarely or never understood, was dependent on staff for activities of daily living, including bathing/showering, dressing, toileting, hygiene, and surface-to-surface transfers, and was not using restraints. During a review of Resident 6's History and Physical (H&P), dated 4/12/2024, the H&P indicated Resident 6 does not have the capacity to understand and make decisions. During a review of Resident 6's Care Plans, last revised 6/26/2024, the care plan indicated the use of right- and left-hand mitten restraints and to release every two hours and as needed to check for circulation and skin integrity. During an observation on 8/20/2024, at 9:50 a.m., inside Resident 6's room, Resident 6 was lying down in bed with mittens on his left and right hands. During an observation on 8/22/2024, at 12:56 p.m., inside Resident 6's room, Resident 6 was lying down in bed with mittens on his left and right hands. During a concurrent interview and record review with Licensed Vocational Nurse (LVN) 5, on 8/22/2024, at 1:13 p.m., Resident 6's medical record was reviewed and LVN 5 confirmed Resident 6 did not have a consent for use of mitten restraints. LVN 5 stated Resident 6 has left and right mitten restraints because he has a history of pulling his gastrostomy tube and pulling it out. LVN 5 stated Resident 6 has had the mitten restraints for a while and was unable to give an exact date of how long the resident has been on restraints. LVN 5 further stated it is important to have a consent for use of restraints to determine if the resident or resident's responsible party is agreeable to the use of restraints. During a concurrent interview and record review with Registered Nurse (RN) 5, on 8/22/2024, at 1:40 p.m., Resident 6's medical record was reviewed, and RN 5 confirmed Resident 6 did not have an active order for use of mitten restraints. RN 5 stated there should be an order for use of mitten restraints because without an order, the staff would not be able to perform the intervention. RN 5 reviewed Resident 6's medical record and confirmed the last assessment performed for Resident 6's mitten restraint use was performed 8/3/2023. RN 5 stated assessments for restraint use should be performed annually, on readmissions, and during a change of condition. RN 5 further stated without an assessment, the facility would not be able to determine if the resident still requires the restraints or not. During a concurrent interview and record review with the Medical Records Director (MRD), on 8/22/2024, at 3:15 p.m., Resident 6's Order Summary Report, dated 2/28/2024, was reviewed and the MRD confirmed Resident 6's order for left- and right-hand mittens to decrease potential injury due to resident behavior of attempting to pull on life sustaining equipment was discontinued. 2. During a review of Resident 126's Admission Record, the Admission Record indicated the facility originally admitted Resident 126 on 3/30/2022 and readmitted the resident on 4/11/2022 with diagnoses including, but not limited to, history of falling and difficulty in walking. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 126's MDS, dated [DATE], the MDS indicated Resident 126 had severe cognitive impairment (difficulty understanding and making decisions), required maximal assistance with rolling left to right in bed, and was dependent on facility staff for other activities of daily living, including eating, dressing, bathing, or showering, hygiene, toileting, and surface-to-surface transfers. Resident 126's MDS indicated the facility used a limb restraint less than daily while in bed and other restraints were not used while in bed. During a review of Resident 126's H&P, dated 3/20/2024, the H&P indicated Resident 126 did not have the capacity to understand and make decisions. During a concurrent observation and interview with LVN 10, on 8/22/2024, at 9:55 a.m., inside Resident 126's room, LVN 10 confirmed Resident 126's bed was placed against the wall with the left side of the bed touching the wall, the head of the bed pointing towards the doorway, and the foot of the bed pointing toward the windows in the room. LVN 10 stated placing the bed against the wall would be considered a restraint because if the resident wanted to get out of bed from her left side, the resident would not be able to. LVN 10 reviewed Resident 126's medical record and confirmed Resident 126 did not have an informed consent to place the bed against the wall and an assessment for placing the resident's bed against the wall. LVN 10 stated Resident 126 has a conservator (a court appointed person or organization that is legally responsible for a person who cannot manage alone) and it is important to obtain an informed consent from the conservator so that they are aware of the risks and benefits for placing the bed against the wall. LVN 10 further stated it is important to perform an assessment prior to placing the bed against the wall to see if it is safe for the resident. During an interview with the Director of Nursing (DON) on 8/23/2024, at 7:10 p.m., the DON stated placing the bed against the wall is considered a restraint. The DON stated the process for using restraints includes obtaining a physician's order, assessing the resident, obtaining a consent for the use of restraints, and creating a care plan. The DON stated it is important to assess residents prior to the use of restraints to check if the restraint is safe to use and if it is appropriate for use. The DON stated assessments should be performed on admission, quarterly, and as needed to evaluate and reevaluate the effectiveness of restraint use and to see if there are less restrictive measures that can be implemented. The DON further stated it is important to obtain an informed consent for the use of restraints to respect the resident or resident's responsible party's right to decide for themselves. During a review of the facility's policy and procedure (P&P) titled, Physical Restraint, last reviewed 4/17/2024, the P&P indicated the licensed nurse shall be responsible for obtaining an order from the attending physician which is to include the specific type of restraint, purpose of the restraint, time and place of application, approaches to prevent decreased functioning when applicable, informed consent obtained from resident or from surrogate decision-maker. The P&P indicated the licensed nurse shall complete the informed consent acknowledgement form. The P&P indicated the facility is to engage in a systematic and gradual process toward reducing restraints. The P&P further indicated when there is a significant decline or improvement in resident's condition, and when physical restraint is no longer effective or appropriate an attempt to discontinue, reduce or modify restraints shall be discussed at the quarterly care plan conference. 44376 (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 9's Admission Record, the Admission Record indicated the facility admitted the resident on 10/23/2018, and readmitted the resident on 7/26/2022, with diagnoses including age-related osteoporosis (a condition in which there is a decrease in the amount and thickness of bone tissue), dementia (a group of symptoms affecting memory, thinking, and social abilities), and history of falling. During a review of Resident 9's H&P, dated 9/20/2023, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 9's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others. The MDS indicated the resident had impairment on both sides of the upper extremity and needed substantial to partial assistance on mobility and activities of daily living (ADLs, all the essential, basic self-care tasks that people need to do every day to keep themselves safe, healthy, clean, and feeling good). During a review of Resident 9's Fall Risk Assessment, dated 8/5/2024, the assessment indicated the resident was high risk for falls. During an observation on 8/20/2024, at 1:24 p.m., during resident screening, inside Resident 9's room, observed Resident 9's bed was placed against the wall on her right side of the bed. During an interview and record review on 8/22/2024, at 3:06 p.m., with RN 4, Resident 9's Order Summary Report, Physical Restraint Assessment Forms, and consents were reviewed. RN 4 confirmed the resident's bed was placed against the wall. RN 4 stated placing the bed against the wall would be considered a restraint. RN 4 stated the resident did not have an order, a restraint assessment and informed consent for placing the resident's bed against the wall. RN 4 stated it is important to obtain an informed consent to honor the resident's right to consent or refuse the treatment. RN 4 stated there should be a restraint assessment and a physician's order for placing the bed against the wall to ensure resident safety During an interview on 8/23/2024, at 7:10 p.m., with the DON, the DON stated placing the bed against the wall would be considered a restraint. The DON stated the staff should have obtained a consent from the resident or resident representative, performed a restraint assessment, and obtained a physician's order prior to placing the bed against the wall to prevent injuries and to ensure the resident's right to consent or refuse a treatment was not violated. During a review of the facility's recent policy and procedure (P&P) titled, Physical Restraint, last reviewed on 4/17/2024, the P&P indicated Physical Restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, and which restrict movement or normal access to the use of one's body. The licensed nurse shall be responsible for obtaining an order from the attending physician, which include: a. Specific type of restraint. b. Purpose of the restraint. c. Time and place of application. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. Approaches to prevent decreased functioning when applicable. e. Informed consent obtained from resident or from surrogate decision-maker. During a review of the facility provided user manual Bed Frame 2 (BF 2), copyright 2005, the manual indicated to evaluate patients for entrapment risk according to facility protocol and monitor patients appropriately. Siderails are intended to be a reminder to the patient of the bed's edges, not a patient-retraining device. During a review of the facility provided Bed Frame 1 (BF 1), copyright 2021, indicated under safety bed positions to make sure the bed is in the low position when the patient is unattended. This may help reduce the possibility of patient falls and the severity of any resultant injuries. Siderails are not intended to be used as restraint devices. Medical personnel should determine the appropriate use of siderails and ensure patient safety. During a review of the facility provided user manual basic care bed from Bed Frame 3 (BF 3), copyright 2005, indicated to evaluate patients for entrapment risk according to facility protocol, and monitor patients appropriately. Make sure all siderails are fully latched when in the raised position. Failure to do either of these could result in serious injury or death. 4. During a review of Resident 467's Admission Record, the Admission Record indicated the facility admitted the resident on 1/26/2024, and readmitted the resident on 8/8/2024, with diagnoses including encephalopathy (a change in how the brain functions), seizures (a sudden, uncontrollable burst of electrical activity in the brain), and altered mental status. During a review of Resident 467's H&P, dated 8/8/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 467's MDS, dated [DATE], the MDS indicated the resident sometimes had the ability to make self-understood and usually understand others. The MDS indicated the resident was dependent on mobility and ADLs. During a review of Resident 467's Fall Risk Assessment, dated 8/8/2024, the assessment indicated the resident was high risk for falls. During an observation on 8/20/2024, at 10:09 a.m., inside Resident 467's room, observed the resident lying in bed with all four side rails up. During a concurrent observation, interview and record review on 8/21/2024, at 12:45 p.m., with RN 7, inside Resident 467's room, RN 7 stated placing all four side rails up would be considered a restraint. Reviewed Resident 467's Order Summary Report, Physical Restraint Assessment Forms, and consents. RN 7 stated the resident did not have an order, a restraint assessment, and informed consent for using all four side rails up. RN 7 stated it is important to have physician's order and perform a restraint assessment to ensure resident safety. RN 7 further stated it is important to obtain an informed consent to honor the resident's right to consent or refuse treatment. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/23/2024, at 7:10 p.m., with the DON, the DON stated raising all four side rails up would be considered a restraint. The DON stated the staff should have obtained a consent from the resident or resident representative, performed a restraint assessment, and obtained a physician's order prior to using all four side rails up to prevent injuries and to ensure the resident's right to consent or refuse a treatment was not violated. During a review of the facility's recent policy and procedure (P&P) titled, Bed Safety and Bed Rails, last reviewed on 4/17/2024, the P&P indicated the use of bed rails is prohibited unless the criteria for use of bed rails have been met. The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. Before using bed rails for any reason, the staff shall inform the resident or resident representative about the benefits and potential hazards associated with bed rails and obtain informed consent. The following information will be included in the consent: a. The assessed medical needs that will be addressed with the use of bed rails; g. The resident's risks from the use of bed of bed rails and how these will be mitigated; h. The alternatives that were attempted but failed to meet the resident's needs; and i. The alternatives that were considered but not attempted and the reasons. During a review of the facility's recent policy and procedure titled, Physical Restraint, last reviewed on 4/17/2024, the P&P indicated Physical Restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, and which restrict movement or normal access to the use of one's body. The licensed nurse shall be responsible for obtaining an order from the attending physician, which include: a. Specific type of restraint. b. Purpose of the restraint. c. Time and place of application. d. Approaches to prevent decreased functioning when applicable. e. Informed consent obtained from resident or from surrogate decision-maker. During a review of the facility provided user manual Bed Frame 2 (BF 2), copyright 2005, the manual indicated to evaluate patients for entrapment risk according to facility protocol and monitor patients appropriately. Siderails are intended to be a reminder to the patient of the bed's edges, not a patient-retraining device. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility provided Bed Frame 1 (BF 1), copyright 2021, it indicated under safety bed positions to make sure the bed is in the low position when the patient is unattended. This may help reduce the possibility of patient falls and the severity of any resultant injuries. Siderails are not intended to be used as restraint devices. Medical personnel should determine the appropriate use of siderails and ensure patient safety. During a review of the facility provided user manual basic care bed from Bed Frame 3 (BF 3), copyright 2005, it indicated to evaluate patients for entrapment risk according to facility protocol, and monitor patients appropriately. Make sure all siderails are fully latched when in the raised position. Failure to do either of these could result in serious injury or death. 43988 5. During a review of Resident 30's Admission Record, the Admission Record indicated the facility admitted the resident on 6/6/2014 and readmitted in the facility on 6/4/2024 with diagnoses including but not limited to dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), adult failure to thrive (a condition that happens when an older adult has a loss of appetite, eats and drinks less than usual, loses weight, and is less active than normal), and gastrostomy status (a surgical procedure used to insert a tube, through the abdomen and into the stomach to provide a route for tube feeding. During a review of Resident 30's History and Physical (H&P), dated 6/5/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 30's MDS, dated [DATE], the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and require total assistance from staff with all ADLs. The MDS indicated a physical restraint was not used on the resident. During a concurrent observation and interview on 8/20/2024 at 11:00 a.m., inside Resident 30's room, with LVN 3, observed Resident 30 lying in bed with pillows tucked under the fitted sheets on both sides of the resident's lower legs. LVN 3 stated the pillows are usually placed by the Certified Nursing Assistant (CNA) on both sides to prevent Resident 30 from falling out of bed due to restlessness. LVN 3 stated the pillows restrict the resident's movements. During a concurrent interview and record review on 8/23/2024 at 4:43 p.m., with MDSC 2, reviewed Resident 30's physician's order, MDS assessment, physical restraint assessments, and informed consents. MDSC 2 stated Resident 30 did not have a physician's order, an informed consent and physical restraint assessment prior to placing the pillows tucked under the fitted sheets. MDSC 2 stated he cannot say that the use of the pillows tucked under the fitted sheet was considered a restraint as the incident may just be an isolated incident to prevent the resident from getting out of bed. During an interview on 8/23/2024 at 7:30 p.m., with the DON, the DON stated placing the pillows under the fitted sheet to prevent the resident from falling out of the bed would be considered a restraint as it restricts the resident's movements by preventing the resident from getting out of bed. The DON stated there should be a physician's order, an informed consent and a physical restraint assessment completed prior to use of pillows tucked under the fitted sheet. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Physical restraints, last reviewed 4/17/2024, the P&P indicated: Physical restraints are a manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, and which restrict freedom of movement or normal access to the use of one's body. The licensed nurse shall be responsible for obtaining an order from the attending physician, which is to include: - Specific type of restraint. - Purpose of the restraint. - Time and place of application. - Approaches to prevent decreased functioning when applicable. - Informed consent obtained from resident or from surrogate decision-maker. The licensed nurse shall complete the Informed Consent Acknowledgement Form.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 43988 Based on interview and record review, the facility failed to accurately code the Minimum Data Set (MDS - a standardized assessment and care screening tool) Assessments dated 10/16/2023, 1/16/2024, and 4/17/2024 for one (1) out of 1 sampled resident (Resident 111) investigated during a review of behavioral-emotional care area by failing to code the resident's diagnosis of Post-Traumatic Stress Disorder (PTSD - a condition that develops when a person has experienced or witnessed a scary, shocking, terrifying, or dangerous event) in the MDS. This deficient practice had the potential to negatively affect Resident 111's plan of care and delivery of necessary care and services while in the facility. Findings: During a review of Resident 111's Admission Record, the Admission Record indicated the facility admitted the resident on 1/11/2021 and readmitted in the facility 2/10/2021 with diagnoses including but not limited to PTSD, schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), and dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). During a review of Resident 111's History and Physical (H&P) dated 9/20/2023, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 111's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 7/18/2024, the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required supervision from staff with eating, partial/moderate assistance with upper body dressing, substantial/maximal assistance with rolling left and right, and dependent on staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS Section I6100 indicated Resident 111 had a diagnosis of PTSD. During a review of Resident 111's MDS Quarterly Assessments Section I6100 dated 10/16/2023, 1/16/2024, and 4/17/2024, the assessments did not indicate the resident had a diagnosis of PTSD. During a review of resident 111's Psychiatric Progress Notes dated 2/21/2024, 3/20/2024, and 5/15/2024, the notes indicated PTSD as one of the resident's diagnoses. During a concurrent interview and record review on 8/23/2024 at 3:06 p.m., with Minimum Data Set Coordinator 1 (MDSC 1), Resident 111's MDS Quarterly Assessments dated 10/16/2023, 1/16/2024, and 4/17/2024 were reviewed. MDSC 1 verified Resident 111's was not coded with diagnosis of PTSD on the Quarterly Assessments. During an interview on 8/23/2025 at 7:10 p.m., with the Director of Nursing (DON), the DON stated all MDS assessments should be coded accurately to generate an accurate picture of the resident's current health status and to provide the resident the necessary care and services. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Resident Assessments, last reviewed 4/17/2024, the P&P indicated all persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information.

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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** 44376 Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for: 1. Two of six sampled residents (Resident 9 and 126) for placement of bed against the wall as a physical restraint (the use of a manual hold to restrict freedom of movement of all or part of a person's body, or to restrict normal access to the person's body) during review of physical restraints. 2. One of six sampled residents (Resident 467) for using all four side rails up during review of physical restraints. 3. One out of six sampled residents (Resident 116) addressing use of urinary catheters (a flexible tube used to empty the bladder and collect urine in a drainage bag). 4. One of six sampled residents (Resident 30) for using pillows tucked under a fitted sheet during review of physical restraints care area. 5. 1 out of 6 sampled residents (Resident 59) for using a self-release seat belt during review of physical restraints. 6. 1 out of 1 sampled resident (Resident 111) with a diagnosis of Post Traumatic Stress Disorder (PTSD - a condition that develops when a person has experienced or witnessed a scary, shocking, terrifying, or dangerous event) investigated during review of behavioral-emotional care area. These deficient practices had the potential to result in inconsistent implementation of the care plan that may lead to a delay in or lack of delivery of care and services. 7. One of five residents (Resident 126) failing to implement the Care Plan (a document outlining a detailed approach to care customized to an individual resident's need) for reaching a goal of 6 hours of sleep reviewed for unnecessary medications. As a result, Resident 126 did not have monitoring for hours of sleep and for the effectiveness and side effects (also known as adverse effects - unwanted, uncomfortable, or dangerous effects that a drug may have) of Melatonin (a medication used to regulate circadian rhythm [body's sleep and wake cycle]), since 7/8/24. This deficient practice had the potential to cause Resident 126 to receive suboptimal (less than the highest standard or quality) care, and inability to assess the effectiveness of Melatonin for sleep, leading to the use of unnecessary medications causing potential side effects (unwanted, unpleasant results of a medication) and negatively impacting their physical, mental, and psychosocial well-being. Findings: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1.a During a review of Resident 9's Admission Record, the Admission Record indicated the facility admitted the resident on 10/23/2018, and readmitted the resident on 7/26/2022, with diagnoses including age-related osteoporosis (a condition in which there is a decrease in the amount and thickness of bone tissue), dementia (a group of symptoms affecting memory, thinking, and social abilities), and history of falling. During a review of Resident 9's History and Physical (H&P), dated 9/20/2023, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 9's Set (MDS, a standardized assessment and care screening tool), dated 8/4/2024, the MDS indicated the resident had the ability to make self-understood and understand others. The MDS indicated the resident had impairment on both sides of the upper extremity and needed substantial to partial assistance on mobility and activities of daily living (ADLs, all the essential, basic self-care tasks that people need to do every day to keep themselves safe, healthy, clean, and feeling good). During a review of Resident 9's Order Summary Report, dated 7/26/2024, the report indicated an order for: -Facility may use less restricting measures prior to initiating resident with physical or chemical restraints. During a review of Resident 9's Fall Risk Assessment, dated 8/5/2024, the assessment indicated the resident was high risk for falls. During an observation on 8/20/2024, at 1:24 p.m., inside Resident 9's room, observed Resident 9's right side of the bed placed against the wall. During an interview and record review on 8/22/2024, at 3:06 p.m., with Registered Nurse 4 (RN 4), reviewed Resident 9's care plans (CP). RN 4 stated placing the resident's bed against the wall is considered a restraint. RN 4 stated the resident did not have a care plan for placing the bed against the wall. RN 4 stated it is important to develop and implement a care plan for placement of bed against the wall to ensure resident safety and to provide consistent care to the resident. During an interview on 8/23/2024, at 7:10 p.m., with the Director of Nursing (DON), the DON stated placing the bed against the wall would be considered a restraint and there should have been a care plan developed to ensure resident safety. The DON stated the failure of the staff to develop a care plan on the use of restraint bed placed against the wall could lead to variations in the care of urinary catheter that can lead to substandard care. During a review of the facility's recent policy and procedure (P&P) titled, The Resident Care Plan, last reviewed on 4/17/2024, the P&P indicated to provide an individualized nursing care plan and to promote continuity of resident care. The nursing care plan acts as a communication instrument between nurses and other disciplines. It contains information of importance for all nurses concerning nursing approach and problem solving. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 467's Admission Record, the Admission Record indicated the facility admitted the resident on 1/26/2024, and readmitted the resident on 8/8/2024, with diagnoses including encephalopathy (a change in how the brain functions), seizures (a sudden, uncontrollable burst of electrical activity in the brain), and altered mental status. During a review of Resident 467's H&P, dated 8/8/2024, the H&P, indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 467's MDS, dated [DATE], the MDS indicated the resident sometimes had the ability to make self-understood and usually understand others. The MDS indicated the resident was dependent on mobility and activities of daily living (ADLs). During a review of Resident 467's Fall Risk Assessment, dated 8/8/2024, indicated the resident was high risk for falls. During an observation on 8/20/2024, at 10:09 a.m., inside Resident 467's room, observed the resident lying in bed with all four side rails up. During a concurrent observation, interview and record review on 8/21/2024, at 12:45 p.m., with Registered Nurse 7 (RN 7), inside Resident 467's room, observed resident was lying in bed with all four side rails up. RN 7 stated placing all four side rails up is considered a restraint. Reviewed Resident 467's care plans RN 7 stated there is no care plan for using four side rails up. RN 7 stated it is important to develop and implement a care plan for using all four side rails up to ensure safety of the resident. During an interview on 8/23/2024, at 7:10 p.m., with the DON, the DON stated raising all four side rails up is considered a restraint. The DON stated Resident 467 should have had a care plan for using four side rails up to ensure safety and consistency in care, and to prevent injuries and delivery of substandard quality of care. During a review of the facility's recent policy and procedure (P&P) titled, The Resident Care Plan, last reviewed on 4/17/2024, the P&P indicated to provide an individualized nursing care plan and to promote continuity of resident care. The nursing care plan acts as a communication instrument between nurses and other disciplines. It contains information of importance for all nurses concerning nursing approach and problem solving. 3. During a review of Resident 116's Admission Record, the Admission Record indicated the facility admitted the resident on 5/23/2024, with diagnoses including type 2 diabetes mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as fuel), acute kidney failure (when the body suddenly lose their ability to function), and urinary tract infection (a condition in which bacteria invade and grow in the urinary tract). During a review of Resident 116's H&P, dated 5/24/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 116's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others. The MDS indicated the resident had an indwelling catheter (a catheter which is inserted into the bladder, via the urethra and remains in situ to drain urine). During a review of Resident 116's Order Summary Report, dated 5/23/2024, the report indicated an order for Foley Catheter French (Fr, the relative size of a catheter) (16)/ (10) milliliters (ml, a unit of volume) attached to bedside drainage bag due to unspecified anatomy anomaly. Every shift. During an observation on 8/20/2024, at 10:32 a.m., inside Resident 116's room, observed the resident with a urinary catheter with a dignity bag (a bag used to cover and hold the catheter drainage/collection bag, so it is not visible) hanging on the right side of the bed frame. During a concurrent interview and record review on 8/23/2024, at 9:18 a.m., with Registered Nurse 5 (RN 5), reviewed Resident 116's Order Summary Report and care plans. RN 5 stated there was an order for the urinary catheter, however, there is no care plan for its (urinary catheter) use. RN 5 stated it was important to have a care plan for using a urinary catheter to document the reason for the insertion, to set goals, and to indicate interventions to mitigate untoward effects of inserting a catheter. RN 5 further stated having a care plan helps in the decision-making process for discontinuation of the catheter. During an interview on 8/23/2024, at 7:10 p.m., with the DON, the DON stated the resident should have a care plan for using a urinary catheter to ensure provision of individualized and relevant care to the resident. The DON stated not having a care plan may result in inconsistent care that may cause resident harm. During a review of the facility's recent policy and procedure (P&P) titled, The Resident Care Plan, last reviewed on 4/17/2024, the P&P indicated to provide an individualized nursing care plan and to promote continuity of resident care. The nursing care plan acts as a communication instrument between nurses and other disciplines. It contains information of importance for all nurses concerning nursing approach and problem solving. 43418 1.b. During a review of Resident 126's Admission Record, the Admission Record indicated the facility originally admitted Resident 126 on 3/30/2022 and readmitted the resident on 4/11/2022 with diagnoses including, but not limited to, history of falling and difficulty in walking. During a review of Resident 126's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 7/6/2024, then MDS indicated Resident 126 had severe cognitive impairment (difficulty understanding and making decisions), required maximal assistance with rolling left to right in bed, and was dependent on facility staff for other activities of daily living, including eating, dressing, bathing or showering, hygiene, toileting, and surface-to-surface transfers. Resident 126's MDS indicated the facility used a limb restraint less than daily while in bed and other restraints were not used while in bed. During a review of Resident 126's History and Physical (H&P), dated 3/20/2024, the H&P indicated Resident 126 did not have the capacity to understand and make decisions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 126's Fall Risk Assessment, dated 7/8/2024, the fall risk assessment indicated Resident 126 was at high risk for falls. During an observation on 8/20/2024, at 10:43 a.m., inside Resident 126's room, Resident 126 was lying down in bed. Resident 126's bed was placed against the wall, with the head of the bed facing the doorway, the foot of the bed facing towards the windows in the room, and the left side of the resident's bed touching the wall. During a concurrent observation and interview on 8/22/2024, at 9:43 a.m., inside Resident 126's room, with Licensed Vocational Nurse (LVN) 10, LVN 10 confirmed Resident 126's bed was placed against the wall, with the left side of the bed touching the wall, the head of the bed facing towards the doorway, and the foot of the bed facing the room's windows. LVN 10 stated placing the bed against the wall is considered a restraint because if the resident wanted to get out from her left side, she would not be able to. LVN 10 reviewed Resident 126's medical record and confirmed Resident 126 does not have a care plan for placing the resident's bed against the wall. LVN 10 further stated care plans help guide staff with providing care for residents. During an interview with the Director of Nursing (DON) on 8/23/2024, at 7:10 p.m., the DON stated placing beds against the wall restricts the movement of residents and can be considered a restraint. The DON stated care plans identify the plan of care for residents during their stay. The DON stated staff, residents, and their responsible parties have access to their care plans. The DON stated when using restraints, the facility should develop a care plan. The DON further stated failing to create a care plan can cause a potential delay in care. During a review of the facility's policy and procedure (P&P) titled, Physical Restraint, last reviewed 4/17/2024, the P&P indicated the plan of care shall specify the reason for the use of the restraint, the type, and when and where it is to be used. During a review of the facility's P&P titled, The Resident Care Plan, last reviewed 4/17/2024, the P&P indicated the nursing care plan acts as a communication instrument between nurses and other disciplines and contains information of importance for all nurses concerning nursing approach and problem solving. 43988 4. During a review of Resident 30's Admission Record, the Admission Record indicated the facility admitted the resident on 6/6/2014 and readmitted the resident on 6/4/2024 with diagnoses including but not limited to dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), adult failure to thrive (a condition that happens when an older adult has a loss of appetite, eats and drinks less than usual, loses weight, and is less active than normal), and gastrostomy status (a surgical procedure used to insert a tube, through the abdomen and into the stomach to provide a route for tube feeding. During a review of Resident 30's History and Physical (H&P) dated 6/5/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Studio City Rehabilitation Center	11429 Ventura Blvd Studio City, CA 91604

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 30's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 8/13/2024, the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and require total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS did not indicate the resident had restraints. During a concurrent observation and interview on 8/20/2024 at 11:00 a.m., inside Resident 30's room, with Licensed Vocational Nurse 3 (LVN 3), observed Resident 30 lying in bed with pillows tucked under the fitted sheets on both sides of the resident's lower legs. LVN 3 stated the pillows are usually placed by the Certified Nursing Assistants (CNAs) on both sides to prevent Resident 30 from getting out of bed due to restlessness. LVN 3 stated the pillows restrict the resident's movements by keeping the legs from dangling at the edge of the bed. During a concurrent interview and record review on 8/23/2024 at 4:43 p.m., with Minimum Data Set Coordinator 2 (MDSC 2). reviewed Resident 30's care plans. MDSC 2 stated Resident 30 does not have a care plan addressing the use of pillows tucked under the fitted sheet to prevent the resident from getting out of bed. During an interview on 8/23/2024 at 7:30 p.m., with the Director of Nursing (DON), the DON stated placing the pillows under the fitted sheet to prevent the resident from falling out of the bed is considered a restraint because it restricts the resident's movements and prevents Resident 30 from getting out of bed. The DON stated the resident should have had a care plan for using pillows under the fitted sheet to make staff aware of the goals and interventions to ensure the safety of the resident. During a review of the facility's policy and procedure (P&P) titled, The Resident Care Plan, last reviewed 4/17/2024, the P&P indicated an objective to provide an individualized nursing care plan and to promote continuity of resident care. The policy indicated the nursing care plan acts as a communication instrument between nurses and other disciplines and contains information of importance for all nurses concerning nursing approach and problem solving. 5. During a review of Resident 59's Admission Record, the Admission Record indicated the facility admitted the resident on 6/6/2014 and readmitted the resident on 6/4/2024 with diagnoses including but not limited to dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), adult failure to thrive (a condition that happens when an older adult has a loss of appetite, eats and drinks less than usual, loses weight, and is less active than normal), and generalized muscle weakness. During a review of Resident 59's History and Physical (H&P) dated 1/27/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 59's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 8/13/2024, the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and require total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated the resident had trunk restraints. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of resident 59's Order Summary Report dated 1/27/2024, the report indicated the following order: - Self-release seat belt (SRSB) while in wheelchair for positioning. Informed consent by physician from responsible party after explanation of risks and benefits. Ensure equipment is in place and functioning properly every shift. During a review of Resident 59's care plans, there was no documented evidence the resident has a care plan for using a self-release belt. During an observation on 8/20/2024 at 12:00 p.m. observed Resident 59 up in the wheelchair with a seat belt around the waist with the string tied at the back of the wheelchair. During a concurrent observation and interview on 8/22/2024 at 11:56 a.m., inside Resident 59's room with the Director of Staff Development Assistant (DSD Asst), observed the resident with SRSB while up in the wheelchair. The DSD Asst demonstrated how the SRSB works. The DSD Asst stated the SRSB has a Velcro (a hook-and-loop fastening system) and buckles that can be easily removed. During a concurrent interview and record review on 8/23/2024 at 2:20 p.m., with Minimum Data Set Coordinator 1 (MDSC 1), reviewed Resident 59's care plans. MDSC 1 stated the resident does not have a care plan addressing the use of SRSB. MDSC 1 stated it is important to develop a care plan, so staff are aware of the interventions in place to ensure resident safety. During an interview on 8/23/2024 at 7:30 p.m., with the Director of Nursing (DON), the DON Resident 59 should have had a care plan for using SRSB, so staff are aware of the interventions in place to meet the resident's needs and ensure resident safety. During a review of the facility's policy and procedure (P&P) titled, The Resident Care Plan, last reviewed 4/17/2024, the P&P indicated an objective to provide an individualized nursing care plan and to promote continuity of resident care. The policy indicated the nursing care plan acts as a communication instrument between nurses and other disciplines and contains information of importance for all nurses concerning nursing approach and problem solving. 6. During a review of Resident 111's Admission Record, the Admission Record indicated the facility admitted the resident on 1/11/2021 and readmitted the resident on 2/10/2021 with diagnoses including but not limited to PTSD, schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), and dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). During a review of Resident 111's History and Physical (H&P) dated 9/20/2023, the H&P indicated the resident did not have the capacity to understand and make decisions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 111's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 7/18/2024, the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required supervision from staff with eating, partial/moderate assistance with upper body dressing, substantial/maximal assistance with rolling left and right, and dependent on staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS Section I6100 indicated Resident 111 has a diagnosis of PTSD. During a review of Resident 111's care plan, the resident does not have a care plan developed addressing the resident's diagnosis of PTSD. During a concurrent interview and record review on 8/23/2024 at 3:08 p.m., with Minimum Data Set Coordinator 1 (MDSC 1), Resident 111's care plans were reviewed. MDSC 1 stated Resident 111 does not have a care plan addressing the resident's diagnosis of PTSD. MDSC 1 stated there should have been a care plan created so staff are aware of proper interventions to assist the resident cope with life stressors. During an interview on 8/23/2024 at 7:30 p.m., with the Director of Nursing (DON), the DON stated there should have been a care plan developed and implemented to address resident 11's diagnosis of PTSD for the staff to be aware of the plan of care and interventions in place to assist the resident and prevent a delay in the care and services needed. During a review of the facility's policy and procedure (P&P) titled, The Resident Care Plan, last reviewed 4/17/2024, the P&P indicated an objective to provide an individualized nursing care plan and to promote continuity of resident care. The policy indicated the nursing care plan acts as a communication instrument between nurses and other disciplines and contains information of importance for all nurses concerning nursing approach and problem solving. During a review of the facility's policy and procedure titled, Trauma-Informed and Culturally Competent Care, last reviewed 4/17/2024, indicated to develop individualized care plans that address past trauma in collaboration with the resident and family as appropriate. 43455 7. During a review of Resident 126's Admission Record (a document containing demographic and diagnostic information,) dated 8/22/24, the Admission Record indicated Resident 126 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including depression (a mental health condition that can cause feelings of sadness, loss of interest in activities and difficulty sleeping.) A review of Resident 126's Minimum Data Set (MDS - a comprehensive resident assessment tool), dated 7/6/24, indicated resident was severely impaired with cognition (mental action or process of acquiring knowledge and understanding) based on the results of the Brief Interview for Mental Status ([BIMS] - a mandatory tool used to screen and identify cognitive condition of residents upon admission into a long-term care facility,) and that symptom presence and frequency for trouble falling or staying asleep, or sleeping too much was not marked. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 126's Order Summary Report, dated 8/22/24, the report indicated Resident 126 was prescribed Melatonin 5 milligram ([mg] - a unit of measure of mass) to give one tablet by mouth at bedtime for supplement, starting 3/30/22. During a review of Resident 126's Medication Administration Record ([MAR] - a record of mediations administered to residents,) for August 2024, the MAR indicated Resident 126 was prescribed Melatonin 5 mg to give one tablet by mouth at bedtime for supplement, at 9 PM. During a review of Resident 126's Care Plan, initiated 7/8/24, the Care Plan indicated a goal of sleep of 6 hours per night. During a review of the facility's Consultant Pharmacist's (CP) Medication Regimen Review ([MRR] - a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication,) document review dated 6/26/24, the document indicated Resident has been on order for Melatonin 5 mg qhs (at bedtime) for supplement. Please consider changing the indication of Melatonin use to: 'for supplement to regulate Circadian rhythm.' Also consider monitor for 'hours of sleep qPM (at evening) and qNOC (at bedtime) shifts' to facilitate drug therapy monitoring. The column marked 'Follow-Through, was empty and did not contain any documentation, dates, or signatures for the review of the CP's recommendations. During an interview on 8/22/24 at 1:14 PM, with the Director of Nursing (DON,) the DON stated that Resident 126's care plan dated 7/8/24 indicated a goal of sleep of 6 hours per night. The DON stated after a thorough search of Resident 126's clinical record the DON was unable to locate documentation for monitoring the number of hours of sleep. The DON stated without monitoring hours of sleep it was unknown if non-pharmacological (that do not involve medications or drugs) interventions (therapies) and/or Melatonin were effective in reaching the goal of 6 hours of sleep and when to make changes to medications such as lowering the dose or discontinuing, leading to the use of unnecessary medications for Resident 126. The DON stated that facility failed to implement the care plan for monitoring for hours of sleep, and that it will be immediately initiated for Resident 126. During a review of the facility's Policy & Procedures, titled Section A Resident Assessment, dated 4/2014, the P&P indicated: 8. The Care Plan shall include: a. Services that are to be furnished to attain or measurable objectives and maintain the resident's highest practicable, physical, mental and psychosocial well-being; d. The resident's goals for admission and desired outcomes; Components of the resident's care plan include: b. Measurable, resident centered goals c. Plan of action 13. Care Plans shall be updated more often, as the resident's condition or needs change. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	14. Resident Rights - Care Planning B. The resident has the right to receive the services and/or items included in the plan of care. Review of facility P&P titled Consultant Pharmacist Services Provider Requirements, dated October 2017, the policy indicated: 5. Identifying one or more current medication references to facilitate the identification of medications and information on contraindications, side effects and/or adverse effects, dosage levels and other pertinent information E. Activities that the consultant pharmacist or off-site pharmacist performs includes, but is not limited to: a. A residents drug regime must be free from unnecessary drugs. An unnecessary drug is any drug when used in: iii. without adequate monitoring iv. without adequate indication for its use.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376 Based on interview and record review, the facility failed to provide care in accordance with professional standards: 1. For five of seven sampled residents (Resident 12, 38, 56, 116 125, and 49) investigated for insulin (a hormone that lowers the level of glucose [a type of sugar] in the blood) use by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous ([SQ] -beneath the skin) insulin administration sites. 2. For one of one sampled resident (Resident 38) investigated during review of anticoagulant use by failing to rotate enoxaparin (medication to prevent and treat blood clots) subcutaneous injection sites. The deficient practice increased the risk that Residents Resident 12, 38, 56, 116, 125, and 49 could experience adverse effects (unwanted, unintended result) from same site subcutaneous administration of insulin such as lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Cross Reference F760 Findings: a. During a review of Resident 116's Admission Record, the Admission Record indicated the facility admitted the resident on 5/23/2024, with diagnoses including type 2 diabetes mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as fuel), acute kidney failure (when the body suddenly lose their ability to function), and urinary tract infection (a condition in which bacteria invade and grow in the urinary tract). During a review of Resident 116's History and Physical (H&P), dated 5/24/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 116's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/30/2024, the MDS indicated the resident rarely to never had the ability to make self-understood and understand others. The MDS indicated the resident was on a high-risk drug class hypoglycemic (medication that lowers blood sugar) (including insulin). During a review of Resident 116's Order Summary Report, dated 5/25/2024, the report indicated an order for: - insulin regular human injection solution (Insulin Regular [Human]) Inject as per sliding scale (varies the dose of insulin based on blood sugar level): if 61-150= 0. If blood sugar (BS) less than (<) 60 may administer 8 ounces (oz., a unit of weight measurement) orange juice and call MD; 151-200= 2; 201-250= 4; 251-300= 6; 301-350= 8; 351-399= 10; 400+ If BS greater than (>) 400, administer12 units (the amount required to lower the blood sugar) and notify MD, subcutaneously every 6 hours for diabetes mellitus (DM) rotate site. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 116's Location of Administration of insulin for 6/2024 to 8/2024, it indicated Insulin Regular Human Injection Solution was administered on the following dates and sites: 6/11/2024 at 5:27 p.m. on the Abdomen-Left Lower Quadrant (LLQ) 6/12/2024 at 11:38 p.m. on the Abdomen-LLQ 6/19/2024 at 6:27 p.m. on the Abdomen-Right Lower Quadrant (RLQ) 6/20/2024 at 11:35 p.m. on the Abdomen-RLQ 6/20/2024 at 5:32 a.m. on the Abdomen-RLQ 6/24/2024 at 5:13 p.m. on the Abdomen-LLQ 6/25/2024 at 11:20 p.m. on the Abdomen-LLQ 7/1/2024 at 5:06 a.m. on the Abdomen-LLQ 7/2/2024 at 11:06 p.m. on the Abdomen-LLQ 7/2/2024 at 1:31 p.m. on the Abdomen-LLQ 7/10/2024 at 5:09 p.m. on the Abdomen-LLQ 7/11/2024 at 11:16 p.m. on the Abdomen-LLQ 7/22/2024 at 11:12 p.m. on the Abdomen-LLQ 7/23/2024 at 11:58 p.m. on the Abdomen-LLQ 7/25/2024 at 11:15 p.m. on the Abdomen-LLQ 7/26/2024 at 11:16 p.m. on the Abdomen-LLQ 8/8/2024 at 12:54 a.m. on the Abdomen-LLQ 8/9/2024 at 11:49 p.m. on the Abdomen-LLQ 8/12/2024 at 5:17 p.m. on the Abdomen-Right Upper Quadrant (RUQ) 8/14/2024 at 12:50 p.m. on the Abdomen-RUQ During a concurrent interview and record review on 8/22/2024, at 3:09 p.m., with Registered Nurse 4 (RN 4), reviewed Resident 116's Order Summary Report, Medication Administration Record (MAR), and Location of Administration sites of insulin for 6/2024 to 8/2024. RN 4 stated there were multiple instances where the insulin administration sites was not rotated. RN 4 stated insulin administration sites should be rotated to prevent bruising and swelling of the skin and to prevent lipodystrophy. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/23/2024, at 7:20 p.m., with the Director of Nursing (DON), the DON stated insulin injections sites should be rotated to prevent skin irritation and lipodystrophy. During a review of the facility's recent policy and procedure (P&P) titled, Insulin Administration, last reviewed on 4/17/2024, the P&P indicated to provide guidelines for the safe administration of insulin to residents with diabetes. Select an injection site. a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility provided Instructions for Use of Humulin ([NAME]-mu-[NAME]) R (insulin human) injection for subcutaneous or intravenous use 3 ml or 10 ml multiple-dose vial (100 units/ML), copyright 1997, it indicated change (rotate) your injection sites within the area you choose for each dose to reduce your risk of getting lipodystrophy (pits in skin or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. b. During a review of Resident 38's Admission Record, the Admission Record indicated the facility admitted the resident on 4/17/2012, and readmitted the resident on 12/19/2023, with diagnoses including functional quadriplegia (a condition that causes complete immobility due to a severe physical disability or frailty, but it is not a true paralysis), type 2 diabetes mellitus, and anoxic brain damage (caused by a complete lack of oxygen to the brain, which results in the death of brain cells after approximately four minutes of oxygen deprivation). During a review of Resident 38's H&P, dated 12/19/2023, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 38's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others. The MDS indicated the resident was on high-risk drug class hypoglycemic (including insulin). During a review of Resident 38's Order Summary Report, the report indicated the following orders: -7/2/2024 Enoxaparin Sodium Injection Solution Prefilled Syringe (anticoagulant) 40 milligrams (mg, a unit of weight)/0.4 milliliters (ml, a unit of volume) (Enoxaparin Sodium). Inject 0.4 ml subcutaneously in the morning for deep vein thrombosis (DVT, the formation of one or more blood clots) prophylaxis (ppx, measures designed to preserve health and prevent the spread of disease) rotate site (as maintenance for long term DVT PPX). -5/28/2024 Novolog Injection Solution (Insulin Aspart). Inject as per sliding scale: if 70-140= 0 < 70 may give 8 oz orange juice and notify MD; 141-220= 1 unit; 221-260= 2 units; 261-280= 3 units; 281-300= 4 units; 301-350= 5 units; 351+= 6 units >350 give 6 units and notify MD, subcutaneously every 12 hours for DM rotate site. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 38's Care Plan (CP) titled, Anticoagulant, (a substance that is used to prevent and treat blood clots), and At risk for bleeding and bruises due to anticoagulant therapy, last revised on 12/20/2023, the CP indicated an intervention to administer medication as ordered. During a review of Resident 38's Location of Administration of Enoxaparin Sodium Injection Solution Prefilled Syringe 40 mg/0.4 ml for 5/2024 to 8/2024, it indicated the following dates and sites of administration: 5/5/2024 at 9:25 a.m. on the Abdomen-Left Upper Quadrant (LUQ) 5/6/2024 at 9:23 a.m. on the Abdomen-LUQ 5/9/2024 at 9:02 a.m. on the Abdomen-LUQ 5/10/2024 at 8:49 a.m. on the Abdomen-LUQ 5/11/2024 at 9:12 a.m. on the Abdomen-LUQ 6/11/2024 at 9:02 a.m. on the Abdomen-LUQ 6/12/2024 at 9:09 a.m. on the Abdomen-LUQ 8/8/2024 at 8:43 a.m. on the Abdomen-RLQ 8/9/2024 at 9:31 a.m. on the Abdomen-RLQ 8/17/2024 at 9:33 a.m. on the Abdomen-RUQ 8/18/2024 at 9:13 a.m. on the Abdomen-RUQ During a review of Resident 38's Location of Administration of Novolog Injection Solution for 6/2024 to 8/2024, it indicated the following dates and sites of administration: 6/9/2024 at 5:11 p.m. on the Abdomen-LLQ 6/20/2024 at 5:37 a.m. on the Abdomen-LLQ 6/21/2024 at 5:27 a.m. on the Abdomen-LLQ 7/8/2024 at 5:20 p.m. on the Abdomen-RLQ 7/9/2024 at 5:13 a.m. on the Abdomen-RLQ 7/14/2024 at 5:13 a.m. on the Abdomen-LLQ 7/16/2024 at 5:18 a.m. on the Abdomen-LLQ 7/17/2024 at 5:03 a.m. on the Abdomen-RLQ (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555686	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Studio City Rehabilitation Center	11429 Ventura Blvd Studio City, CA 91604

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/18/2024 at 5:06 a.m. on the Abdomen-RLQ 7/23/2024 at 5:12 a.m. on the Abdomen-RLQ 7/24/2024 at 5:31 a.m. on the Abdomen-RLQ During a concurrent interview and record review on 8/22/2024, at 3:15 p.m., with RN 4, reviewed Resident 38's Order Summary Report, MAR, and Location of Administration sites of insulin from 6/2024 to 8/2024 and Enoxaparin Sodium Injection from 5/2024 to 8/2024. RN 4 stated there were multiple instances where the insulin and enoxaparin administration sites were not rotated. RN 4 stated the insulin and enoxaparin administration sites should be rotated to prevent bruising and swelling of the skin and to prevent lipodystrophy. During an interview on 8/23/2024, at 7:20 p.m., with the DON, the DON stated insulin and enoxaparin injection sites should be rotated to prevent skin irritation and lipodystrophy. During a review of the facility's recent policy and procedure (P&P) titled, Insulin Administration, last reviewed on 4/17/2024, the P&P indicated to provide guidelines for the safe administration of insulin to residents with diabetes. Select an injection site. a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility provided instructions for use of Enoxaparin Sodium Injection for subcutaneous use single-dose prefilled syringe, undated, it indicated to alternate between the left or the right side of the stomach each time an injection is given. During a review of the facility provided Instructions for Use of Humulin ([NAME]-mu-[NAME]) R (insulin human) injection for subcutaneous or intravenous use 3 ml or 10 ml multiple-dose vial (100 units/ML), copyright 1997, it indicated change (rotate) your injection sites within the area you choose for each dose to reduce your risk of getting lipodystrophy (pits in skin or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. During a review of the facility provided Highlights of Prescribing Information for Insulin Aspart injection, for subcutaneous or intravenous use, with initial U.S. approval in 2000, indicated to rotate the injection sites within the same region from one injection to the next to reduce the risk of lipodystrophy and localized cutaneous amyloidosis. c. During a review of Resident 125's Admission Record, the Admission Record indicated the facility admitted the resident on 2/26/2022, and readmitted the resident on 3/1/2024, with a diagnosis of type 2 diabetes mellitus. During a review of Resident 125's H&P, dated 3/1/2024, the H&P indicated the incapacitated resident requires visit for safety. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 125's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and sometimes understands others. The MDS indicated the resident was on a high-risk drug class hypoglycemic (including insulin). During a review of Resident 125's Order Summary Report, dated 4/2/2024, the report indicated an order for Insulin Aspart FlexPen Solution Pen-injector 100 unit/ml (Insulin Aspart). Inject as per sliding scale: if 60-150= 0 units; 151-199= 2 units; 200-249= 3 units; 250-299= 5 units; 300-349= 7 units; 350-400= 10 units; subcutaneously every 12 hours for diabetes type 2 (DM II) (rotate injection sites) finger-stick blood sugar (FSBS, a method of monitoring blood sugar) monitoring. Notify MD if BS < 70 mg/dl or >400 mg/dl. May give 8 oz orange juice if BS < 70 mg/dl and notify MD. During a review of Resident 125's Location of Administration of Insulin Aspart FlexPen Solution Pen-injector 100 unit/ml from 6/2024 to 8/2024, it indicated the following administration dates and sites: 6/4/2024 at 5:15 a.m. on the Abdomen-LLQ 6/7/2024 at 5:06 a.m. on the Abdomen-LLQ 6/10/2024 at 5:38 a.m. on the Abdomen-LLQ 6/11/2024 at 5:26 a.m. on the Abdomen-LLQ 6/12/2024 at 5:05 a.m. on the Abdomen-LLQ 6/13/2024 at 5:33 a.m. on the Abdomen-LLQ 6/17/2024 at 5:36 a.m. on the Abdomen-LLQ 6/19/2024 at 5:14 a.m. on the Abdomen-LLQ 6/20/2024 at 5:31 a.m. on the Abdomen-LLQ 6/21/2024 at 5:19 a.m. on the Abdomen-LLQ 6/24/2024 at 5:19 a.m. on the Abdomen-RLQ 6/26/2024 at 5:15 a.m. on the Abdomen-RLQ 6/27/2024 at 5:24 a.m. on the Abdomen-RLQ 7/8/2024 at 5:12 a.m. on the Abdomen-RLQ 7/9/2024 at 5:15 a.m. on the Abdomen-RLQ 7/10/2024 at 5:11 a.m. on the Abdomen-RLQ 7/11/2024 at 5:09 a.m. on the Abdomen-RLQ (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/12/2024 at 5:07 a.m. on the Abdomen-RLQ 7/15/2024 at 5:16 a.m. on the Abdomen-RLQ 7/17/2024 at 5:07 a.m. on the Abdomen-RLQ 7/18/2024 at 5:08 a.m. on the Abdomen-RLQ 7/21/2024 at 5:30 a.m. on the Abdomen-RLQ 7/22/2024 at 5:10 a.m. on the Abdomen-RLQ 7/23/2024 at 5:16 a.m. on the Abdomen-RLQ 7/24/2024 at 5:33 a.m. on the Abdomen-RLQ 7/25/2024 at 5:20 a.m. on the Abdomen-RLQ 8/1/2024 at 5:07 a.m. on the Abdomen-RLQ 8/2/2024 at 5:03 a.m. on the Abdomen-RLQ During a review of Resident 125's Care Plan (CP) titled, Resident at risk for hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) related to diabetes mellitus, last revised on 3/9/2022, the CP indicated an intervention to administer medications as ordered. During a concurrent interview and record review on 8/22/2024, at 3:19 p.m., with RN 4, reviewed Resident 125's Order Summary Report, MAR, and Location of Administration sites of insulin from 6/2024 to 8/2024. RN 4 stated there were multiple instances where the insulin administration sites were not rotated. RN 4 stated insulin administration should be rotated to prevent bruising and swelling of the site and to prevent lipodystrophy. During an interview on 8/23/2024, at 7:20 p.m., with the DON, the DON stated insulin injections sites should be rotated to prevent skin irritation and lipodystrophy. During a review of the facility's recent policy and procedure (P&P) titled, Insulin Administration, last reviewed on 4/17/2024, the P&P indicated to provide guidelines for the safe administration of insulin to residents with diabetes. Select an injection site. a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility provided Highlights of Prescribing Information for Insulin Aspart injection, for subcutaneous or intravenous use, with initial U.S. approval in 2000, it indicated to rotate the injection sites within the same region from one injection to the next to reduce the risk of lipodystrophy and localized cutaneous amyloidosis. 43455 d.1 During a review of Resident 12's Admission Record (a document containing demographic and diagnostic information,) dated 8/22/24, it indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Type 2 Diabetes Mellitus 2 ([DM2] - a condition where there is high blood sugar levels.) During a review of Resident 12's Order Summary Report, dated 8/22/24, it indicated Resident 12 was prescribed Lantus (long-acting insulin) to inject 20 units ([un] - a measure of dosage for insulin) SQ at bedtime for DM rotate sites, starting 2/21/24. During a review of Resident 12's Medication Administration Record ([MAR] - a record of mediations administered to residents), for August 2024, the MAR indicated Resident 12 was prescribed Lantus 20 un SQ to give at bedtime for DM rotate sites, at 9 PM. During the same review, the MAR indicated Lantus 20 units SQ was administered at bedtime on the following days and sites: 8/13/24 at 9 PM on Right Upper Quadrant ([RUQ] - upper right side of abdomen) 8/14/24 at 9 PM on RUQ d.2 During a review of Resident 56's Admission Record (a document containing demographic and diagnostic information,) dated 8/21/24, it indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including DM2. During a review of Resident 56's Order Summary Report, dated 8/21/24, it indicated Resident 56 was prescribed Novolog (fast-acting insulin) to inject per sliding scale (insulin dosing plan whereby the amount of insulin administered depends on the resident's blood sugar level,) SQ before meals for DM2 (rotate site,) starting 10/13/23. During a review of Resident 56's MAR for June and July 2024, the MAR indicated Resident 56 was prescribed Novolog to inject per sliding scale SQ before meals for DM2 (rotate site,) at 6:30 AM, 11:30 AM and 4:30 PM. During the same review, the MAR's indicated Novolog SQ was administered on the following days, times and sites: 6/27/24 at 6:30 AM on Left Lower Quadrant ([LLQ] - lower left side of abdomen) 6/27/24 at 4:30 PM on LLQ 6/28/24 at 6:30 AM on Right Lower Quadrant ([RLQ] - right left side of abdomen) (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/27/24 at 4:30 PM on RLQ 6/30/24 at 11:30 AM on RLQ 6/30/24 at 4:30 PM on RLQ 7/10/24 at 4:30 PM on LLQ 7/11/24 at 4:30 PM on LLQ 7/23/24 at 4:30 PM on LLQ 7/24/24 at 4:30 PM on LLQ During a concurrent interview and record review on 8/23/24 at 8:57 AM, with Registered Nurse (RN) 7, RN 7 reviewed Resident 12's and 56's MAR for August 2024 and for June and July 2024, respectively. RN 7 stated that Resident 12 MAR indicated to rotate injection sites for Lantus and Resident 56 MARs indicated to rotate injection site for Novolog. RN 7 stated that for Resident 12 and 56 the MARs indicated there were multiple instances where the insulin administration sites were not rotated by several licensed nurses, as expected by standard of practice, manufacturer guidelines, and MAR order instructions. RN 7 stated the failure of the licensed nurses to rotate insulin administration sites could cause harm to Resident 12 and 56 by causing skin abnormalities such as lumps in the skin or thickened skin. During an interview on 8/23/24, at 10:19 AM, with the Director of Nursing (DON,) the DON stated that per facility policy and manufacturer guidelines it was common knowledge for licensed nurses to rotate insulin administration sites to prevent lipodystrophy to the sites that was frequently administered with insulin. The DON stated that several licensed nurses failed to rotate the insulin administration sites for Resident 12 and 56 and placed the residents at risk of harm from lipodystrophy. A review of facility's Policy and Procedures (P&P) titled, Insulin Administration, dated September 2014, the P&P indicated: To provide guidelines for the safe administration of insulin to residents with diabetes. 3. The type of insulin, .and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order. 16.b. injection sites should be rotated, preferably within the same general area. A review of manufacturer's guide for Injecting Lantus with a vial and syringe, dated 2022, the guide indicated to Change (rotate) your injection sites within the area you chose with each dose to reduce your risk of getting lipodystrophy (pitted or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. Do not use the same spot for each injection or inject where the skin is pitted, thickened, lumpy, tender, bruised, scaly, hard, scarred or damaged. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of manufacturer's guide for Instructions for use for Novolog, dated 1/2015, the guide indicated Injection sites should be rotated within the same region to reduce the risk of lipodystrophy. For each injection, change (rotate) your injection site within the area of skin that you use. Do not use the same injection site for each injection. 43988 e. During a review of Resident 49's Admission Record, the Admission Record indicated the facility admitted the resident on 8/4/2021 and readmitted in the facility on 5/8/2024 with diagnoses including but not limited to heart failure (a long-term condition that happens when the heart cannot pump blood well enough to give the body a normal supply), type two diabetes mellitus (DM 2 - a long term condition that causes the level of sugar [glucose] in the blood to become too high), and dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). During a review of Resident 49's History and Physical (H&P) dated 5/10/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 49's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 8/13/2024, the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and require total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 49 received insulin. During a review of Resident 49's Order Summary Report, the report indicated the following physician's order dated 5/8/2024: o Basaglar KwikPen (insulin glargine - a long-acting insulin used to control high blood sugar) subcutaneous solution pen-injector 100 unit per milliliter (unit/ml - a unit of measurement) inject 20 units subcutaneously in the morning for DM rotate sites. o Basaglar KwikPen (insulin glargine - a long-acting insulin used to control high blood sugar) subcutaneous solution pen-injector 100 unit per milliliter (unit/ml - a unit of measurement) inject 20 units subcutaneously at bedtime for DM rotate sites. o Humalog KwikPen (insulin lispro - a quick acting insulin used to improve blood sugar control in people with DM) subcutaneous solution Pen-injector 100 unit/ml (insulin lispro) inject subcutaneously per sliding scale: if 60 - 130 = 0; 131 - 160 = 2; 161 - 200 = 3; 201 - 250 = 4; 251 - 300 = 6; 301 - 350 = 8; 351 - 400 = 10 more than 400= 10 units and call physician ,before meals and at bedtime for DM [ROTATE SITE] notify physician if blood sugar is above 400 milligram per deciliter (mg/dl - a unit of measurement or below 60mg/dl, may give five 8 ounces (oz - a unit of measurement) orange juice by mouth if blood sugar is below 60mg/dl. o Fiasp injection solution (insulin aspart with niacinamide - a rapid acting insulin indicated to improve glycemic control in patients with DM) 100 unit /ml inject seven (7) unit subcutaneously before meals for DM 2 (ROTATE SITES) notify physician if blood sugar is above 400 mg/dl or below 60mg/dl, may give 8oz orange juice by mouth if blood sugar is below 60mg/dl. Hold for blood sugar less than 100 administer 10-15 minutes prior to eating meals or as close as possible to mealtime. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 49's Medication Administration Record (MAR) from 6/2024 to 8/2024, the MAR indicated Basaglar insulin injection solution was administered as follows: 6/7/2024 9:00 a.m. subcutaneously Abdomen Right lower Quadrant (RLQ) 6/7/2024 9:00 p.m. subcutaneously Abdomen RLQ 6/8/2024 9:00 a.m. subcutaneously Abdomen Right Upper Quadrant (RUQ) 6/8/2024 9:00 p.m. subcutaneously Abdomen RUQ 6/13/2024 9:00 a.m. subcutaneously Right Arm (RA) 6/13/2024 9:00 p.m. subcutaneously RA 6/14/2024 9:00 a.m. subcutaneously Abdomen RUQ 6/14/2024 9:00 p.m. subcutaneously Abdomen RUQ 6/22/2024 9:00 a.m. subcutaneously Abdomen RLQ 6/22/2024 9:00 p.m. subcutaneously Abdomen RLQ 7/1/2024 9:00 a.m. subcutaneously Abdomen RUQ 7/1/2024 9:00 p.m. subcutaneously Abdomen RUQ 7/12/2024 9:00 a.m. subcutaneously Abdomen Left Upper Quadrant (LUQ) 7/12/2024 9:00 p.m. subcutaneously Abdomen LUQ 7/15/2024 9:00 a.m. subcutaneously Abdomen Left Lower Quadrant (LLQ) 7/15/2024 9:00 p.m. subcutaneously Abdomen LLQ 7/17/2024 9:00 a.m. subcutaneously Abdomen Left Lower Quadrant (LLQ) 7/17/2024 9:00 p.m. subcutaneously Abdomen LLQ 7/19/2024 9:00 a.m. subcutaneously Abdomen RLQ 7/19/2024 9:00 p.m. subcutaneously Abdomen RLQ 7/23/2024 9:00 a.m. subcutaneously Abdomen RLQ 7/23/2024 9:00 p.m. subcutaneously Abdomen RLQ 7/25/2024 9:00 a.m. subcutaneously Abdomen LUQ (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/25/2024 9:00 p.m. subcutaneously Abdomen LUQ 7/31/2024 9:00 a.m. subcutaneously Abdomen RLQ 7/31/2024 9:00 p.m. subcutaneously Abdomen RLQ During a review of Resident 49's Medication Administration Record (MAR) from 6/2024 to 8/2024, the MAR indicated Humalog insulin injection solution was administered as follows: 06/20/2024 9:00 p.m. subcutaneously Abdomen - Left Lower Quadrant (LLQ) 06/21/2024 11:30 subcutaneously Abdomen - LLQ 06/23/2024 11:30 subcutaneously Abdomen - LLQ 06/23/2024 21:00 subcutaneously Abdomen - LLQ 07/04/24 21:00 subcutaneously Abdomen - LUQ 07/06/24 11:30 subcutaneously Abdomen - LUQ 07/16/24 21:00 subcutaneously Abdomen - Left Lower Quadrant (LLQ) 07/17/24 11:30 subcutaneously Abdomen - LLQ 08/01/24 11:30 subcutaneously Abdomen - LLQ 08/01/24 16:30 subcutaneously Abdomen - LLQ 08/19/24 11:30 subcutaneously Abdomen - LLQ 08/19/24 16:30 subcutaneously Abdomen - LLQ During a review of Resident 49's Medication Administration Record (MAR) from 6/2024 to 8/2024, the MAR indicated Fiasp insulin injection solution was administered as follows: 06/08/24 16:30 subcutaneously Abdomen - LUQ 06/09/24 11:30 subcutaneously Abdomen - LUQ 08/08/24 11:30 subcutaneously Abdomen - LUQ 08/08/24 16:30 subcutaneously Abdomen - LUQ 08/10/24 16:30 subcutaneously Abdomen - LUQ 08/11/24 06:30 subcutaneously Abdomen - LUQ (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	08/19/24 11:30 subcutaneously Abdomen - LLQ 08/19/24 16:30 subcutaneously Abdomen - LLQ During a concurrent interview and record review on 8/23/2024 at 3:30 p.m., with Minimum Data Set Coordinator 2 (MDSC 2), reviewed Resident 49's physician's orders, MAR, and location of administration sites from 6/2024 to 8/2024. MDSC 2 verified the physician's order that indicated to rotate insulin administration sites. MDSC 2 stated there were multiple repeated insulin administration on the same sites between 6/2024 to 8/2024. During an interview on 8/23/2024 at 7:10 p.m., the Director of Nursing (DON), the DON stated the licensed nurses should rotate the insulin administration site to prevent residents from developing lipodystrophy. During a review of the facility's policy and procedure (P&P) titled, Insulin Administration, last reviewed 4/17/2024, the P&P indicated a purpose to provide guidelines for the safe administration of insulin to residents with diabetes. The policy indicated: o Insulin maybe injected into the SQ tissues of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately two (2) inches around the navel. o Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility provided manufacturer's guideline for Basaglar (insulin glargine), undated, it indicated to rotate injection sites into the abdominal area, thigh, or deltoid to reduce the risk of lipodystrophy and localized cutaneous amyloidosis. During a review of the facility provided manufacturer's guideline for Humalog (insulin lispro), undated, it indicated: - Change (rotate) your injections sites within the area you choose for each dose to reduce your risk of getting lipodystrophy and localized cutaneous amyloidosis. - Do not inject where the skin has pits, is thickened, or has lumps. - Do not inject where the skin is tender, bruised, scaly or hard, or into scars or damaged. During a review of the facility provided manufacturer's guideline for Fiasp (insulin aspart), undated, it indicated to rotate injection sites within the same region to reduce the risk of lipodystrophy and localized cutaneous amyloidosis.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 44376 Based on observation, interview, and record review the facility failed to ensure residents received care consistent with professional standards of practice to prevent pressure injury (the breakdown of skin integrity due to pressure) for two of four sampled residents (Residents 67 and 469) investigated during review of pressure injury by failing to: 1. Ensure Resident 67's low air loss mattress' (LALM, designed to distribute the resident's body weight over a broad surface area and help prevent skin breakdown) power was turned on. 2. Ensure Resident 469's LALM was set according to the resident's weight. The deficient practices had the potential for the development and worsening of the resident's pressure ulcers/injuries. Findings: 1. During a review of Resident 67's Admission Record, the Admission Record indicated the facility admitted the resident on 5/2/2018, and readmitted the resident on 10/9/2023, with diagnoses including hemiplegia (one-sided muscle paralysis or weakness) and hemiparesis (one-sided muscle weakness), peripheral vascular disease (a slow and progressive disorder of the blood vessels), and venous thrombosis (a blood clot that blocks the flow of blood through the veins) and embolism (a block in an artery caused by blood clots or other substances, such as fat globules, infected tissue, or cancer cells). During a review of Resident 67's History and Physical (H&P), dated 10/9/2023, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 67's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/28/2024, the MDS indicated the resident had the ability to make self-understood and understand others. The MDS indicated the resident had an impairment on one side of the upper and lower extremity. The MDS indicated the resident was dependent on mobility and activities of daily living (ADLs, all the essential, basic self-care tasks that people need to do every day to keep themselves safe, healthy, clean, and feeling good) and was incontinent of urine and bowel (feces). The MDS further indicated the resident was at risk for developing pressure ulcer/injuries and used a pressure reducing device for bed. During a review of Resident 67's Order Summary Report, dated 10/10/2023, the report indicated an order for Low Air Loss Mattress for wound care and management. During a review of Resident 67's Wound Risk Assessment, dated 5/30/2024, the assessment indicated the resident was high risk for skin breakdown. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 67's Care Plan (CP) titled, Low-Air Loss Mattress. At risk for falling from Low-Air-Loss Mattress due to: Specify (involuntary movements, spontaneous movements, large or heavy patients, resident with contractures, resident requiring total care, resident requiring turning and repositioning), initiated on 8/20/2024, the CP indicated an intervention to ensure LAL mattresses are inflated and recommended. During a concurrent observation and interview on 8/20/2024, at 12:34 p.m., with Licensed Vocational Nurse 5 (LVN 5), inside Resident 67's room, observed the resident's LALM power off. LVN 5 stated the resident's LALM is off, and it should have been set at 150 to prevent the resident from developing pressure injury. During an interview on 8/23/2024, at 7:10 p.m., with the Director of Nursing (DON), the DON stated staff should have turned on the power of the LALM to provide therapy to the resident. The DON stated the failure of staff to turn the power on could result to therapy not being provided and predisposes the resident to developing or worsening of pressure injuries. During a review of the facility provided Operation Manual for Low Air Loss Mattress (LALM), undated, the manual indicated press Power key on the panel, the pump will start/stop operation. Users can adjust air mattress to a desired firmness according to patient's weight or the suggestion from a health care professional. 43988 2. During a review of Resident 469's Admission Record, the Admission Record indicated the facility admitted the resident on 8/8/2024, with diagnoses including respiratory failure (a serious condition that makes it difficult to breathe), tracheostomy (an opening surgically created through the neck into the trachea [windpipe] to allow air to fill the lungs), and traumatic subdural hemorrhage (happens when blood is leaking out of a torn blood vessel and below the space of the brain and the skull). During a review of Resident 469's History and Physical (H&P), dated 8/8/2024, The H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 469's Order Summary Report, the report indicated the following orders: -8/19/2024 Low Air Loss Mattress for wound care and management. -8/14/2024 Sacral area pressure ulcer (P.U.). Cleanse with normal saline (NS, a mixture of water and salt for washing wounds). Pat dry. Apply Santyl ointment (a topical medication used for removing damaged or burned skin to allow for wound healing and growth of healthy skin). Cover with dry dressing (DD) then bordered gauze (an absorptive dressing consisting of three layers). Every day shift for 30 days. During a review of Resident 469's Care Plan titled, Actual Pressure Sore. Resident is noted with stage 3 P.U. (a full-thickness loss of skin that extends into the subcutaneous tissue, but does not reach muscle, tendon, or bone), initiated on 8/9/2024, the CP indicated an intervention of using pressure relieving devices as needed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 469's Wound Risk Assessment, dated 8/15/2024, the assessment indicated the resident was high risk for skin breakdown. During a review of Resident 469's Weight Summary, dated 8/15/2024, it indicated the resident's weight was 136 pounds (lbs., a unit of weight). During a concurrent observation and interview on 8/20/2024, at 11:22 a.m., with Certified Nursing Assistant 3 (CNA 3), inside Resident 469's room, observed the LALM set at 160 and the sticker on the device indicated to set at 200. CNA 3 stated the LALM was set at 160 but the the sticker indicated to set the LALM at 200. During a concurrent interview and record review on 8/23/2024, at 11:33 a.m., with Treatment Nurse 3 (TN 3), reviewed Resident 469's Weight Summary. TN 3 stated the LALM is set according to the weight of the resident. TN 3 stated the resident's latest weight on 8/15/2024 was 136 lbs. TN 3 stated the sticker should not indicate to set at 200. TN 3 stated the sticker could be misleading and could cause staff to set the LALM in an inappropriate setting that can cause the development or worsening of a pressure injury. TN 3 stated they should have clarified with the attending physician as to what the LALM setting should be. During an interview on 8/23/2024, at 7:10 p.m., with the Director of Nursing (DON), the DON stated the LALM should be set according to the resident's weight. The DON stated the staff should have clarified with the attending physician the order for the LALM setting. The DON stated the failure of the staff to clarify the order could lead to provision of inappropriate therapy that can cause the development or worsening of the pressure injury. During a review of the facility provided Operation Manual for the LALM , undated, the manual indicated press Power key on the panel, the pump will start/stop operation. Users can adjust air mattress to a desired firmness according to patient's weight or the suggestion from a health care professional.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41379 Based on observation, interview, and record review, the facility failed to provide appropriate treatments and services to minimize decline in joint range of motion (ROM, full movement potential of a joint) and mobility for three of five sampled residents (Residents 6, 138, and 125) who had limited ROM by failing to: 1. Provide Resident 6 with a right knee splint (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) during Restorative Nursing Aide Program (RNA, nursing aide program that help residents to maintain their function and joint mobility) seven (7) times a week as ordered and report to nursing when Resident 6 did not complete range of motion exercises or wear the right knee splint. 2. Provide Resident 125 with a left elbow splint and both hand rolls (device to keep fingers open) 7 times a week as ordered and report to nursing when Resident 125 did not wear a left elbow splint and both hand rolls. 3. Provide Resident 138 with left elbow splint, left resting hand splint, and right hand roll 7 times a week as ordered and report to nursing when Resident 138 did not wear left elbow splint, left resting hand splint, and right hand roll. The deficient practices had the potential to cause decline in ROM, mobility, and overall physical functioning in Resident 6, 125 and 138. Findings: a. During a review of Resident 6's Admission Record (AR) dated 8/22/24, the AR indicated Resident 6 initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including respiratory failure (any condition that affects breathing function and result in lungs not functioning properly), Parkinson's disease (progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement) without dyskinesia (involuntary movements of extremities), and functional quadriplegia (weakness or paralysis to all four extremities). During a review of Resident 6's History and Physical (H&P) dated 4/12/24, the H&P indicated Resident 6 did not have the capacity to understand and make decisions. During a review of Resident 6's Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated 6/21/24, the MDS indicated Resident 6 was severely impaired in cognitive skills for daily decision making. The MDS indicated Resident 6 required dependent assistance (helper does all of the effort) with dressing, oral hygiene, toileting hygiene, and bathing. The MDS also indicated Resident 6 had functional limitations in range of motion impairments on both sides of the upper extremities (UE, shoulder, elbow, wrist/hand) and both sides of lower extremities (LE, hip, knee, ankle/foot). (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 6's Order Summary Report dated 8/1/24, the Order Summary Report indicated an order dated 5/9/24 for RNA/Nursing Program established for active assistive range of motion (AAROM, movement at a given joint with a person's own effort and assistance from an external force or another person) for both UE (BUE), passive range of motion (PROM, movement at a given joint with full assistance from another person) for both LE (BLE) as tolerated followed by right knee splint, and both ankle foot orthosis (AFO, an orthotic device designed to correct or address problems with the ankle and foot) for four to six (4-6) hours or as tolerated, once a day, 7 times a week. During a review of Resident 6's care plan dated 5/9/24, the care plan indicated Resident 6 had limitations in range of motion and contractures (loss of motion of a joint). The care plan goal was to minimize complications related to decreased mobility or contractures through appropriate interventions through the next assessment. The care plan interventions indicated restorative nursing for AAROM to BUE, PROM to BLE, right knee splint and both AFOs for 4-6 hours or as tolerated 7 times a week, and orthotic application and skin integrity management. During a review of Resident 6's Physical Therapy (PT, a rehabilitation profession that restores, maintains, and promotes optimal physical function) Discharge Summary (PT DC) dated 5/9/24, the PT DC indicated discharge recommendations for an RNA program for PROM for BLE followed by right knee splint and B AFOs for 4-6 hours or as tolerated 7 times a week. During a review of Resident 6's Documentation Survey Report for RNA intervention/task dated July 2024, the RNA report indicated Resident 6 completed 15 minutes of PROM 7 days a week. The RNA report did not indicate when Resident 6 did or did not wear the right knee splint or AFOs. During a review of Resident 6's Documentation Survey Report for RNA intervention/task dated August 2024, the RNA report indicated Resident 6 completed 15 minutes of PROM 7 days a week. The RNA report did not indicate when Resident 6 did or did not wear the right knee splint or AFOs. During a review of Resident 6's Restorative Nursing Weekly Summary - Splint Care dated 8/16/24, the Splint Care Weekly Summary indicated Resident 6 had right knee splint and both AFO with a wearing schedule of four to six hours in AM. The Splint Care Weekly Summary indicated not applicable to questions in other, refuses to wear, resident takes off, and indicated no for change of condition. During a review of Resident 6's Physical Therapy Joint Mobility Screening (PT JMS) dated 8/21/24, the PT JMS indicated Resident 6 had severe ROM loss (more than 50 percent (%) loss) in both hips and in the right knee, minimal ROM loss (less than 25% loss) in both ankles. The PT JMS indicated Resident 6 had minimal to severe loss of lower extremity passive ROM, and chart review indicated Resident 6 had a diagnosis or condition that put him at risk for contracture development. The recommendation was to continue RNA program. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 8/22/24 at 9:24 AM with Restorative Nursing Aide (RNA 1) of Resident 6's RNA treatment session in Resident 6's room, RNA 1 stated Resident 6 had an RNA order for AAROM for BUE and PROM for BLE and a right knee splint and both AFOs. RNA 1 removed a white hand mitten from Resident 6's right hand and started to bend and straighten Resident 6's right knee. Resident 6's right knee was in a fully bent position and RNA 1 could straighten the right knee a little. RNA 1 moved the right leg outward and in towards the body, and ankle away and towards the body. RNA 1 was able to move the ankles a little. RNA 1 stated Resident 6 had pain with moving lower extremity so RNA 1 would try the upper extremity. RNA 1 attempted to straighten right elbow which were in bent position. RNA 1 stated Resident 6 was resisting, stopped the RNA treatment, left the room, and reported to Licensed Vocational Nurse (LVN 5). RNA 1 returned to Resident 6's room and stated RNA 1 would put on the AFOs. RNA 1 attempted to move left arm up, stated Resident 6 was resistive and stopped. RNA 1 retrieved both AFOs from cabinet and put on both ankles/feet. RNA 1 retrieved a blue right knee splint, attempted to straighten the right knee, stated Resident 6 was resisting and did not put right knee splint on. LVN 5 entered the room and RNA 1 reported to LVN 5 that Resident 6 could not put on the right knee splint. RNA 1 stated Resident 6 was able to wear the right knee splint yesterday for about four to six hours, but usually Resident 6 could not wear the knee splint about four times a week. During a concurrent interview and record review on 8/22/24 at 9:52 AM, RNA 1 stated on 8/18/24 Resident 6 did not tolerate the right knee splint. RNA 1 reviewed RNA daily task documentation on 8/18/24 and stated no, he did not document that Resident 6 did not tolerate the right knee splint. RNA 1 stated he did not report this to the charge nurse. RNA 1 stated Resident 6 had not been tolerating the right knee splint about three to four times a week for many weeks but could not remember for how long. RNA 1 stated he should have documented and reported to nursing and rehabilitation department whenever Resident 6 did not tolerate any part of the RNA treatment, including when Resident 6 was resisting range of motion and ROM could not be completed or could not wear the right knee splint. During an interview on 8/22/24 at 11:43 AM, LVN 5 stated today was the first time that RNA 1 reported that Resident 6 did not tolerate the ROM exercises or did not wear the right knee splint. During an interview and record review on 8/22/24 at 1:52 PM with Physical Therapist (PT 1), the PT DC Summary dated 5/9/24 was reviewed. PT 1 stated the PT recommended an RNA program for BLE PROM followed by putting on right knee splint and both AFOs for 4-6 hours. PT 1 stated PTs recommend RNA program for PROM and splinting to help stretch the muscle and prevent further contractures. PT 1 stated contractures can limit a person's mobility, for example a contracture can prevent you from sitting, transferring to a shower chair, and moving around in bed. PT 1 stated when an RNA program was created, it was the expectation that the RNAs follow the whole RNA program, because the RNA program was established specifically for Resident 6 to help prevent contractures. PT 1 stated today was the first time PT 1 was aware that Resident 6 could not tolerate the right knee splint. PT 1 stated it was important for RNA to report if Resident 6 could not tolerate any part of the RNA program because PT could assess and complete an PT evaluation if needed and to assess of the current RNA program and knee splint was still appropriate for Resident 6. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 8/22/24 at 2:36 PM with Registered Nurse (RN 1) and Registered Nurse (RN 5), Resident 6's clinical records were reviewed. RN 1 and RN 5 stated they were both the RN supervisors for Resident 6. RN 1 and RN 5 reviewed Resident 6's orders and stated Resident 6 had an RNA order for AAROM BUE, PROM BLE, R knee splint and both AFOs for 4-6 hours or as tolerated 7 days a week. RN 1 and RN 5 stated the RNA should be completing the whole RNA treatment order and that if Resident 6 could not complete any part of the order, then the RNA should report that to nursing and rehab dept. RN 1 and RN 5 stated they had not received any reports from RNA or nursing that Resident 6 could not tolerate any part of the RNA program in the last three months. RN 1 and RN 5 stated if Resident 6 could not tolerate any part of the RNA program, then the RNAs should document that the resident could not tolerate the RNA treatment. After a review of Resident 6's RNA documentation, RN 1 and RN 5 stated the RNAs did not document that Resident 6 did not tolerate any part of the RNA program. RN 1 and RN 5 stated the RNAs should report the first time Resident 6 did not tolerate the splint and that it was important to report, because it was a change of condition and because Resident 6 could get worse. RN 1 and RN 5 stated if nursing was aware, then they could complete a change of condition report, inform the physician, and get orders or referrals as needed, so that the facility can start to intervene, so it did not get worse. During an interview on 8/22/24 at 2:56 PM, the Certified Nursing Assistant (CNA 1) he was a regular CNA for Resident 6. CNA 1 stated sometimes Resident 6 had a right knee splint and sometimes Resident 6 did not. CNA 1 stated Resident 6 did not wear a right knee splint every day. During an interview on 8/22/24 at 4:41 PM, the Director of Nursing (DON) stated the RNA program was a restorative nursing program to help make sure the mobility of residents was maintained. DON stated if the RNAs were not following the RNA order, then there was a risk of decline in function for the residents. DON stated it was important for RNAs to notify nursing so that they could notify the physician and rehab dept so that the facility could further assess and intervene. During a review of the facility's policy and procedure titled, Restorative Nursing Program, last reviewed 4/17/24, the P&P indicated the purpose of the RNA program was to maintain residents functional ability and to reduce further decline. The P&P also indicated weekly assessments are to be made of the resident's progress in the RNP by the restorative nurse and documented in the resident's medical record. Any change in the resident's condition or response to treatment is reported to nursing and documented in the medical record. 2. During a review of Resident 125's AR dated 8/22/24 indicated Resident 125 initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including, but not limited to acute and chronic respiratory failure, acquired absence of right leg above knee, acquired absence of left leg above knee, hemiplegia (weakness to one side of the body) affecting left nondominant side. During a review of Resident 125's MDS dated [DATE], the MDS indicated Resident 125 was severely impaired in cognitive skills for daily decision making. The MDS indicated Resident 125 had functional limitations in ROM impairments on BUE and BLE. The MDS also indicated Resident 125 required dependent assistance with oral hygiene, dressing, toileting hygiene, and bathing. During a review of Resident 125's Order Summary Report dated 8/1/24, the Order Summary Report indicated an order dated 4/11/24 for RNA/Nursing program for PROM for BUE and BLE as tolerated followed by both hand rolls, both AFOs, and left elbow splint for 4-6 hours or as tolerated, once a day, 7 times a week. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 125's care plan dated 4/11/24, the care plan indicated Resident 125 had limitations in range of motion and contractures. The care plan goal was to minimize complications related to decreased mobility or contractures through appropriate interventions through the next assessment. The care plan interventions indicated restorative nursing for PROM for BUE and BLE, splinting with both hand rolls, and left elbow splint for 4-6 hours or as tolerated 7 times a week, with orthotic application and skin integrity management for BUE. During a review of Resident 125's Occupational Therapy (OT, rehabilitative profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) Discharge Summary (OT DC) dated 4/11/24, the OT DC indicated Resident 125 had ROM limitations in both shoulders and both elbows/forearms. The OT DC indicated a recommendation for RNA to facilitate resident maintaining current level of performance to prevent decline for splint care and PROM. During a review of Resident 125's Documentation Survey Report for RNA intervention/task dated July 2024, the RNA report indicated Resident 125 put on a splint every day (except 7/6/24) for either 4 or 6 hours. The RNA report did not indicate what splint was put on (left elbow splint or right or left hand rolls and time each splint was worn). The RNA report did not indicate if Resident 125 completed PROM exercises for BUE or BLE. During a review of Resident 125's Documentation Survey Report for RNA intervention/task dated August 2024, the RNA report indicated Resident 125 put on a splint every day (except 8/15/24) for either 2,4, or 6 hours. The RNA report did not indicate what splint was put on (left elbow splint or right or left hand rolls and time each splint was worn). The RNA report did not indicate if Resident 125 completed PROM exercises for BUE or BLE. During a review of Resident 125's Restorative Nursing Weekly Summary - Splint Care dated 5/5/24, the RNA Weekly Summary indicated Yes to splint, hand roll, and brace on right and left hand/arm splint and right and left leg. The RNA Weekly Summary indicated a wearing schedule of 6 hours in AM and no change of condition. The RNA Weekly Summary also indicated resident will continue with RNA orders. During a review of Resident 125's Restorative Nursing Weekly Summary - Splint Care indicated there were no other RNA Splint Care Weekly Summaries completed after 5/5/24. During a review of Resident 125's Occupational Therapy Joint Mobility Screening (OT JMS) dated 7/24/24, the OT JMS indicated Resident 125 had minimal passive ROM loss (less than 25% loss) on both wrists, minimal loss on both hands/fingers, minimal loss on right elbow, moderate loss (less than 50% loss) on left elbow, and moderate loss on both shoulders. The OT JMS indicated Resident 125 had minimal to severe loss of UE PROM and chart review indicated Resident 125 had a diagnosis/condition that puts him at risk for contracture development. During an observation on 8/20/24 at 11:37 AM in Resident 125's room, Resident 125 was asleep, and the left elbow was bent more than halfway. Resident 125 did not have any splints or hand rolls on the LUE. Resident 125 had above knee amputations on both legs. During an observation on 8/20/24 at 1:55 PM in Resident 125's room, Resident 125 was awake and able to move the right arm to grab the upper side rail on the right side. Resident 125's left elbow was bent more than halfway and left hand was relaxed and resting on the body. Resident 125 did not have any hand rolls or elbow splints on BUE. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 8/21/24 at 8:30 AM in Resident 125's room, Resident 125 was awake, and the left elbow was bent more than halfway, the left wrist was slightly bent and the left fingers were straight. Resident 125 did not have any splints or hand rolls on BUE. During an observation on 8/21/24 at 11:03 AM in Resident 125's room, Resident 125 was awake, and the left elbow was bent more than halfway, left wrist slightly bent and left hands were relaxed. Resident 125 did not have any splints or hand rolls on BUE. During an observation on 8/21/24 at 1:52 PM in Resident 125's room, Resident 125 was awake, and the left elbow was bent fully, left wrist slightly bent and left fingers were straight. Resident 125 did not have any splints or hand rolls on BUE. During an observation and interview on 8/22/24 at 8:13 AM with Restorative Nursing Aide (RNA 2) of Resident 125's RNA treatment session in Resident 125's room, RNA 2 bent and straightened Resident 125's left elbow. RNA 2 was able to straighten the left elbow to about halfway. RNA 2 completed PROM to both UE and lifted both amputated legs up and down. RNA 2 completed the PROM exercises and did not put on any splints or hand rolls on Resident 125 during the RNA treatment session. During an interview and record review on 8/22/24 at 8:32 AM with RNA 2, RNA 2 stated he worked with Resident 125 a lot because they were assigned certain stations and residents. RNA 2 stated he performed PROM with Resident 125 everyday and RNA 2 stated he did not think Resident 125 had any splints because Resident 125's hands were not contracted. RNA 2 reviewed Resident 125's RNA orders and RNA documentation and stated Resident 125 had an RNA order for PROM for BUE and BLE followed by both hand rolls and left elbow splint for 4-6 hours as tolerated seven times a week. RNA 2 stated he was not putting hand rolls of left elbow splint on Resident 125, because he thought Resident 125 graduated from that. RNA 2 stated he informed the DOR. RNA 2 confirmed Resident 125 had an order to put on a left elbow splint and both hand rolls and that Resident 125 should wear the elbow splint and hand rolls. RNA 2 confirmed the RNA daily documentation indicated that RNA 2 was putting on the splint every day. RNA 2 stated that he should have put N/A if he was not putting on the elbow splint or hand rolls. RNA 2 stated he should have documented whenever he reported to nursing and DOR that Resident 125 did not put on elbow splint and hand rolls. RNA 2 reviewed the RNA weekly summaries for splint care and confirmed the last one completed was 5/5/24. RNA 2 stated he never put on any UE splints for Resident 125. RNA 2 stated it was only for the BLE but Resident 125 had an amputation, so he stopped putting on the LE splints for Resident 125. RNA 2 confirmed he continued to document in RNA daily task that he spent 15 min putting on splints and that Resident 125 tolerated the splints for 4 or 6 hours. RNA 2 stated that the documentation was not accurate and did not reflect what RNA 2 completed with Resident 125 during RNA treatment. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 8/22/24 at 10:57 AM, Registered Nurse (RN 4) stated the purpose of the RNA program was for RNAs to perform ROM and put splints on the residents in order to prevent contractures. RN 4 stated the RNAs should follow and complete the orders for RNA program for each resident. RN 4 stated if the resident could not tolerate any part of the order due to pain, then the RNA should notify the charge nurse or RN supervisor to inform nursing that the resident was in pain. RN 4 stated that if the resident could not put on a splint for any reason as ordered, then the RNA should report it so it could be documented. RN 4 stated she was not aware that Resident 125 was not wearing the splints or hand rolls. RN 4 stated the RNA documentation should reflect that Resident 125 was not wearing the elbow splint or hand rolls. RN 4 reviewed the RNA documentation in August 2024 and stated the RNA documentation indicated Resident 125 was wearing the splint every day. RN 4 stated it was important to document correctly to show if the resident was getting worse or better and to show what actually happened. RN 4 stated RNAs should be documenting N/A if they were not putting on the splints or hand rolls. During an interview on 8/22/24 at 3:32 PM, the DOR stated he was not aware that Resident 125 was not wearing the left elbow splint or hand rolls. DOR stated the RNAs should have been putting on the left elbow splint and both hand rolls because that was the RNA order. DOR stated the RNAs should be reporting to their nursing supervisor if they were not putting on the splints and hand rolls and should not be a decision that RNA could make to not put on the splint. During an interview on 8/22/24 at 4:27 PM, DON stated RNAs should be following the RNA orders and that if Resident 125 was not tolerating or completing any part of the RNA order, then the RNA should report it. DON stated the RNA documentation was not accurate since May 2024 since the RNAs were not putting on the splints and hand rolls. DON stated the RNAs need to communicate and report to nursing who can then report to the physician and therapy or complete a change of condition to assess so that the facility can intervene and do something about it. During a review of the facility's policy and procedure titled, Restorative Nursing Program, last reviewed 4/17/24, the P&P indicated the purpose of the RNA program was to maintain residents functional ability and to reduce further decline. The P&P also indicated weekly assessments are to be made of the resident's progress in the RNP by the restorative nurse and documented in the resident's medical record. Any change in the resident's condition or response to treatment is reported to nursing and documented in the medical record. 3. During a review of Resident 138's AR dated 8/22/24, the AR indicated Resident 138 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including but not limited to chronic respiratory failure, intracerebral hemorrhage (bleeding in the brain). During a review of Resident 138's MDS dated [DATE], the MDS indicated Resident 138 was severely impaired in cognitive skills for daily decision making. The MDS indicated Resident 138 required dependent assistance with dressing, oral hygiene, toileting hygiene, and bathing. The MDS also indicated Resident 138 had functional limitations in range of motion impairments on BUE and BLE. During a review of Resident 138's Order Summary Report dated 8/1/24, the Order Summary Report indicated an order dated 7/1/24 for RNA/Nursing Program for active range of motion (AROM, movement at a given joint when the person moves voluntarily) or AAROM for BUE and BLE as tolerated followed by sitting at edge of bed as tolerated followed by left resting hand splint, left elbow extension splint, and right hand roll for 4-6 hours or as tolerated, once a day, seven times a week. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 138's care plan dated 7/1/24, the care plan indicated Resident 138 had limitations in range of motion and contractures. The care plan goal was to minimize complications related to decreased mobility or contractures through appropriate interventions through the next assessment. The care plan interventions indicated restorative nursing for AAROM to BUE and BLE, left resting hand splint, left elbow extension splint and right hand roll for 4-6 hours or as tolerated seven times a week, and orthotic application and skin integrity management, and sitting at edge of bed as tolerated. During a review of Resident 138's OT JMS dated 7/1/24, the OT JMS indicated Resident 138 had full range of motion in right wrist, right hand/fingers, and right elbow and minimal ROM loss in left wrist. The OT JMS also indicated Resident 138 had moderate ROM loss in left elbow and left hand/fingers. The OT JMS indicated chart review indicated Resident 138 had a diagnosis or condition that put him at risk for contracture development and RNA training was completed with 100% return demonstration. During a review of Resident 138's Documentation Survey Report for RNA intervention/task dated August 2024, the RNA report indicated Resident 138 tolerated a splint for 4 hours on 8/16/24, 8/17/24, 8/18/24, 8/19/24, 8/20/24, and 8/21/24. The RNA report did not indicate if which splint was put on for 4 hours, if ROM exercises were completed, or if sitting edge of bed activity was completed. During a review of Resident 138's Restorative Weekly Summary - Splint Care dated 8/19/24, the RNA Weekly Summary indicated no for splint, yes for hand roll, not applicable for hand/arm splint with a wearing schedule of 4-6 hours in AM. The RNA Weekly Summary indicated no for refuses to wear, no for resident takes off, no for change of condition, no for charge nurse notified. During an observation and interview on 8/20/24 at 1:55 PM in Resident 138's room, Resident 138 was lying in bed. Resident 138's left and right elbows were bent and the left hand was in a fisted position. Resident 138 did not have any splints or hand rolls. Resident 138 stated he did not receive any splints for the hand today. During an observation and interview on 8/21/24 at 11:03 AM in Resident 138's room, Resident 138 stated he received exercises today, but did not have a hand roll or any splints. Resident 138 was using his left hand to hold a tablet. During an observation and interview on 8/21/24 at 1:52 PM in Resident 138's room, Resident 138 stated he used to wear a left elbow splint, but they stopped putting it on. Resident 138 proceeded to use his right arm to grab his left wrist and attempted to straighten his left arm but could not fully straighten the left elbow. Resident 138 stated he used to have a hand roll for the left hand, but it got lost and he never received another one. Resident 138 was able to open the left hand and straighten the left fingers. Resident 138 stated he received his exercises but not the splints or hand rolls. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 8/22/24 at 8:32 AM, RNA 2 stated he performed AAROM for BUE and BLE and sitting edge of bed with Resident 138. RNA 2 stated sometimes he put on the hand roll and left elbow splint and sometimes Resident 138 wore the splint and hand roll for 1-2 hours. RNA 2 stated if Resident 138 only wore left elbow splint and hand roll for 1-2 hours, then he should document it. RNA 2 stated if Resident 138 did not wear the splints or hand roll, then he should document that Resident 138 did not wear the splints. RNA 2 reviewed the August RNA treatment record and stated the August RNA documentation showed Resident 138 wore the splints every day for 4 hours. RNA 2 stated it was not documented that Resident 138 only wore the left elbow splint and hand roll for 1-2 hours. RNA 2 stated there was no place to document if Resident 138 completed ROM or sat edge of bed. RNA 2 stated Resident 138 did not complete sitting edge of bed exercises every day, but there was nowhere to document that. During an interview and record review on 8/22/24 at 11:15 AM, RN 4 stated she was not aware of Resident 138 not wearing or tolerating the elbow splint or hand rolls. RN 4 stated she did not see Resident 138 wearing an elbow splint or hand splints. RN 4 stated Resident 138 was alert and oriented and was able to tell you if he put on an elbow splint, hand splint, or hand rolls. RN 4 reviewed Resident 138's RNA daily documentation in August 2024 and stated the RNA documentation indicated the resident was wearing the splints for 4 hours on 8/21/24. RN 4 stated if Resident 138 was wearing the splint for only 1 hour, then the documentation should indicate the resident wore it for 1 hour and not 4 hours. RN 4 stated the RNA documentation was not accurate. RN 4 stated the documentation should be accurate because we would think Resident 138 was wearing the splint for 4 hours, but in reality, he was only wearing it for 1 hour so we are not getting accurate information for assessments and to make decisions on his care. During an interview on 8/22/24 at 4:35 PM, DON stated RNA program was a restorative nursing program to help make sure the mobility of residents was maintained. DON stated if the RNAs were not following the RNA order, then there was a risk of decline in function for the residents. DON stated it was important for RNAs to notify nursing so that they could notify the physician and rehab dept so that the facility could further assess and intervene. DON stated the RNA documentation for Resident 138 was not accurate and RNAs should not put 4 hours if the RNA was not putting on the splints or only putting on splints for 1 hour. DON stated the RNA should report to nursing anytime they were not following the RNA order for any reason. DON also stated there was nowhere in the RNA documentation to document if the resident completed the edge of bed exercises or ROM, it only indicated if the resident put on the splint and for how long. During a review of the facility's policy and procedure titled, Restorative Nursing Program, last reviewed 4/17/24, the P&P indicated the purpose of the RNA program was to maintain residents functional ability and to reduce further decline. The P&P also indicated weekly assessments are to be made of the resident's progress in the RNP by the restorative nurse and documented in the resident's medical record. Any change in the resident's condition or response to treatment is reported to nursing and documented in the medical record.

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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** 44376 Based on observation, interview, and record review the facility failed to ensure the resident's environment was free of accident hazards for four out of four sampled residents (Residents 74, 73, 30, and 19) by failing to ensure: 1. Resident 74's oxygen concentrator (a medical device that separates nitrogen from the air so that 95% of pure oxygen can be breathed in) was not placed on top of the fall mat (safety features that are placed on the floor along the side of the bed in the home or next to a hospital bed). The deficient practice lessened the effectiveness of the fall mat to prevent falls with injury by placing a heavy equipment and furniture on top of the fall mat, decreasing its effectiveness to lessen the impact of a fall due to permanent dented mat surface and potential of the residents hitting the hard surfaces of the heavy equipment and furniture. 2. Resident 73's low bed (a bed less than a foot from the floor) was placed at the lowest position after performing resident care. The deficient practice of not keeping the bed in its lowest position placed the resident at risk for falls resulting in injuries, and even death. 3. Resident 30's long pull cord for the resident's tab alarm (fall management device system that enables reliable monitoring of individuals at risk of falls, whether in a bed, wheelchair, or the restroom) was not long enough to entangle and choke the resident. This deficient practice had the potential to result in resident sustaining injury caused by the length of the string attached to the resident with a with a clip from the tab alarm device. 4. Resident 19's one open tube of hydrocortisone cream (a topical medication used to treat skin conditions such as itching and swelling) one percent (%, a unit of measurement) and one tube of petroleum jelly (a topical ointment used to treat or prevent minor skin irritations) were not left unattended and readily available at the resident's bedside. This deficient practice had the potential to result in residents self-administering medications without staff knowledge resulting in overdose, poisoning from ingestion, or a delay in care and services. Findings: 1. During a review of Resident 74's Admission Record, the Admission Record indicated the facility admitted the resident on 5/11/2024, and readmitted the resident on 5/23/2024, with diagnoses including tracheostomy (an opening surgically created through the neck into the trachea [windpipe] to allow air to fill the lungs), dementia (a range of neurological conditions affecting the brain that worsens over time), and transient ischemic attack (TIA, a stroke that lasts only a few minutes). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 74's History and Physical (H&P), dated 5/23/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 74's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/18/2024, the MDS indicated the resident rarely to never had the ability to make-self understood and sometimes understand others. The MDS indicated the resident was dependent on mobility and activities of daily living (ADLs, all the essential, basic self-care tasks that people need to do every day to keep themselves safe, healthy, clean, and feeling good). During a review of Resident 74's Order Summary Report indicated the following orders: -7/10/2024 Frequent visual monitoring due to high risk for fall and injury. Document every shift. -6/20/2024 Low bed with floor mat to decrease potential injury. (informed consent obtained from resident representative [RP] after explanation of risks and benefits and verified with MD). Ensure equipment is in place and functioning well. Every shift. During a review of Resident 74's Fall Risk Assessment, dated 8/20/2024, the assessment indicated the resident was high risk for falls. During a review of Resident 74's Care Plan (CP) titled, Resident is at risk for falls/injury related to cerebrovascular accident (CVA, an interruption in the flow of blood to cells in the brain)/TIA, dementia, difficulty walking, generalized weakness, impaired cognition (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life), impaired vision, poor body balance/control, poor safety awareness/judgment, use of medications such as (antihypertensive [medications that lower blood pressure], psychotropic [medications that affect the mind, emotions, and behavior], hypoglycemic agents [medications that lower blood sugar]), initiated on 5/18/2024, the CP indicated an intervention to provide resident with a safe and clutter-free environment. During a concurrent observation and interview on 8/20/2024, at 12 p.m., with the Director of Nursing (DON), inside Resident 74's room, observed the bilateral fall mats of the resident with oxygen concentrators on top of them . The DON stated there should be no heavy equipment or furniture on top of the fall mats to prevent denting them permanently, lessening the effectiveness of the mat to lessen the impact of the fall. The DON further stated placing the heavy equipment and furniture on top of the fall mat can cause injury to the resident as they could land on the hard and sharp surfaces of the equipment and furniture resulting in injuries or even death. During a review of the facility's recent policy and procedure (P&P) titled, Accident/Incident Prevention, last reviewed on 4/17/2024, the P&P indicated this facility strives to prevent accidents by providing an environment that is free from accident hazards over which the facility has control, as well as identification of each resident at risk for accidents/incidents and the provision of adequate care plans with procedures to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 73's Admission Record, the Admission Record indicated the facility admitted the resident on 4/5/2017, and readmitted the resident on 5/2/022, with diagnoses including epilepsy (a disorder of the brain characterized by repeated seizures), hemiplegia (one-sided muscle paralysis or weakness), and hemiparesis (one-sided muscle weakness), and nontraumatic intracerebral hemorrhage (bleeding in the brain that occurs without trauma or surgery). During a review of Resident 73's H&P, dated 5/4/2024, the H&P indicated the resident is incapacitated resident requires visit for safety. During a review of Resident 73's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others. The MDS also indicated the resident had highly impaired vision and was dependent on mobility and activities of daily living (ADLs). During a review of Resident 73's Order Summary Report, dated 7/10/2024, the report indicated an order for Falling Star Program (a patient assessment program that identifies residents who are at high risk for falling). Frequent visual monitoring due to high risk for fall and injury. Document every shift. During a review of Resident 73's Fall Risk Assessment, dated 7/12/2024, the assessment indicated the resident was high risk for falls. During a review of Resident 74's Care Plan (CP) titled, Falling Star Program. At risk for falls related to antihypertensive medications, balance deficit, bladder/bowel dysfunction(s), cognitive impairment, decreased strength/endurance, seizure disorder, initiated on 7/10/2024, the CP indicated an intervention to provide low bed if indicated. During a concurrent observation and interview on 8/20/2024, at 11:07 a.m., with Certified Nursing Assistant 3 (CNA 3), inside Resident 74's room, observed the resident's bed left in the high position. CNA 3 measured the height of the bed using a tape measure and the bed was 31 inches off the floor. CNA 3 stated the bed was too high and should be placed at the lowest position after providing resident care to prevent falls that can result to injuries. During an interview on 8/23/2024, at 7:10 p.m., with the DON, the DON stated the beds should be left at the lowest position when not providing care to residents to prevent falls resulting in injuries and possibly death. During a review of the facility's recent policy and procedure (P&P) titled, Accident/Incident Prevention, last reviewed on 4/17/2024, the P&P indicated this facility strives to prevent accidents by providing an environment that is free from accident hazards over which the facility has control, as well as identification of each resident at risk for accidents/incidents and the provision of adequate care plans with procedures to prevent accidents. During a review of the facility provided Bed Frame 1 (BF 1) manual, copyright 2021, it indicated under safety bed positions to make sure the bed is in the low position when the patient is unattended. This may help reduce the possibility of patient falls and the severity of any resultant injuries. 43988 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 30's Admission Record, the Admission Record indicated the facility admitted the resident on 6/6/2014 and readmitted the resident on 6/4/2024 with diagnoses including but not limited to dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), adult failure to thrive (a condition that happens when an older adult has a loss of appetite, eats and drinks less than usual, loses weight, and is less active than normal), and gastrostomy status (a surgical procedure used to insert a tube, through the abdomen and into the stomach to provide a route for tube feeding. During a review of Resident 30's History and Physical (H&P) dated 6/5/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 30's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 8/13/2024, the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and require total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 30 had a bed alarm. During a review of Resident 30's Order Summary Report dated 6/4/2024 indicated: [Non-restraint] Tab alarm when in bed and wheelchair/gerichair to alert/remind resident to ask for assistance when transferring or ambulating. (Informed consent obtained by physician from responsible party after explanation of risks and benefits and verified with physician). Ensure equipment is in place and functioning properly every shift. During a Resident 30's care plan (CP), the CP on tab alarm, last revised on 7/22/2024 with target date 10/18/2024, indicated when in wheelchair/bed/gerichair to alert/remind the resident to ask for assistance when transferring or ambulating and to monitor the alarm for good working condition and proper placement as needed as one of the interventions. During a review of Resident 30's fall risk assessments dated 4/13/2024, 6/4/2024, and 7/22/2024, the assessments indicated the resident is a high risk for falls. During a concurrent observation and interview on 8/21/2024 at 12:36 p.m. inside Resident 30's room with Licensed Vocational Nurse 3 (LVN 3), observed the resident in bed using a tab alarm. attached to the left upper siderail with a strap with the long pull cord attached to the resident's clothing secured by a clip. LVN 3 stated the long pull cord was long enough and can potentially cause injury to the resident by getting wrapped around the neck or arm of the resident resulting in an injury such as entanglement or choking. LVN 3 verified the current length of the cord did not activate the tab alarm even when the resident was moving a lot in bed. LVN 3 stated the pull cord should be short enough to prevent any injury and for the pull cord to detach from the tab alarm to alert the staff and the resident. During an interview on 8/23/2024 at 7:40 p.m., with the Director of Nursing (DON), the DON stated the tab alarm should be at a length that will activate the alarm by detaching the sensor from the sensor area when the resident moves to ensure resident safety. The DON stated the long pull cord could potentially wrap around any part of the resident's arm or neck causing injury resulting from entanglement or choking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (H&P) titled, Accident/Incident Prevention, last reviewed on 4/17/2024, the H&P indicated the facility strives to prevent accidents by providing an environment that is free from accident hazards over which the facility has control, as well as identification of each resident at risk for accidents/incidents and the provision of adequate care plans with procedures to prevent accidents. During a review of the facility provided manufacturer's guideline for Medical Equipment 1 (ME 1), undated, it indicated the alarm improves patient safety by alerting caregivers when a patient attempts to get out of a wheelchair or bed without assistance. The manufacturer's guideline indicated: - Be sure that the long pull cord cannot entangle or choke the user. Use the pull cord adjuster to adjust the length of the pull cord. - A pull on the cord from any direction will cause the magnetic sensor to release from the sensor area therefore sounding the alarm. - Long pull cord can entangle the patient and be potentially dangerous. Use with care and supervision. 44244 4. During a review of Resident 19's Admission Record, the Admission Record indicated the facility admitted the resident on 6/24/2024 with diagnoses that included unspecified fracture (break in the bone) of the lower right end of the right femur (upper bone of the leg), cognitive (mental action or process of acquiring knowledge and understanding) communication deficit (lack thereof), and unspecified dementia (general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). During a review of Resident 19's Minimum Data Set (MDS - an assessment and care screening tool) dated 7/1/2024, the MDS indicated the resident required substantial/maximal assistance with toileting and dressing; and required supervision with oral and personal hygiene. During a review of Resident 19's History and Physical (H&P) dated 6/24/2024, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 19's Self-Administration of Drugs Assessment form, dated 6/24/2024, the form indicated the interdisciplinary team determined that it was not safe for the resident to self-administer drugs due to physical/functional impairment secondary to multiple diagnosis. During a concurrent observation and interview on 8/20/2024 at 9:34 a.m., observed Resident 19 lying in bed, observed an open container of hydrocortisone 1 % cream and one open container of petroleum jelly on the resident's rolling bedside table, no staff were present. Resident 19 stated she applies both medications on her lips every now and then. During an observation on 8/20/2024 at 9:41 a.m., observed Restorative Nursing Assistant 3 (RNA 3) enter Resident 19's room, speak with resident, and then exit the room. Observed the hydrocortisone cream and petroleum jelly remained visible on the bedside table. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 8/20/2024 at 10:06 a.m., observed Certified Nursing Assistant 2 (CNA 2) stood in Resident 19's doorway and stated there were two ointments on the resident's nightstand. CNA 2 stated Resident 19 likes to have the ointments on her bedside table to use for her lips. CNA 2 stated Resident 19 applies the ointments herself. Observed CNA 2 walked away from Resident 19's room and the hydrocortisone and petroleum jelly remained at bedside. During a concurrent interview and record review on 8/22/2024 at 11:57 a.m., Licensed Vocational Nurse 8 (LVN 8) reviewed Resident 19's physician orders. LVN 8 stated residents should not have medications left at bedside because staff would not know if the resident needed or used the medication. LVN 8 stated all medications require physician orders that indicates the dosage, route, frequency, and reason for the medication. LVN 8 stated Resident 19 did not have an order for hydrocortisone or petroleum jelly. LVN 8 stated Resident 19 should not have hydrocortisone left at bedside, but she can have petroleum jelly for her lips. LVN 8 stated the CNA should have known to remove the hydrocortisone from Resident 19's bedside because there was a chance the resident would overuse the medication and there was a potential for other residents to get the medication. During an interview on 8/23/2024 at 1:33 p.m., with the Assistant Director of Nursing (ADON), the ADON stated Resident 19 was not safe for self-administration of medication and hydrocortisone and petroleum jelly should not be left at bedside. The ADON stated anything applied topically to the resident required an order. The ADON stated a physician's order is required for self-administration, and Resident 19 did not have an order self-administration. The ADON stated when medications are left at bedside there is a potential that other residents may ingest the medication causing them harm. During a review of the facility policy and procedure (P&P) titled, Administering Medications, last reviewed 4/17/2024, the P&P indicated medications are administered in a safe manner. Residents may self-administer their own medication only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely. During a review of the facility policy and procedure (P&P) titled, Self-Administration of Medications, last reviewed 4/17/2024, the P&P indicated residents who desire to self-administer medications are permitted to do so if the facilities interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility. All nurses and aides are required to report to the charge nurse on duty any medications found at bedside not authorized for bedside storage and to give unauthorized medications to the charge nurse for return to the family or responsible party. During a review of the facility policy and procedure (P&P) titled, Accident/Incident Prevention, last reviewed 4/17/2024, the (P&P) indicated the facility strives to prevent accidents by providing an environment that is free from accident hazards over which the facility has control, as well as identification of each resident at risk for accidents/incidents and the provision of adequate care plans with procedures to prevent accidents.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44244 Based on observation, interview, and record review the facility failed to ensure residents with urinary incontinence (loss of bladder control) received appropriate treatment and services to prevent urinary tract infections (UTI, an infection in the urinary system) for three of six sampled residents (Resident 417, 158 and 150) investigated during review of urinary catheters (indwelling catheter/Foley catheter/FC, a flexible tube inserted into the bladder to drain urine into a collection bag) care area by failing to: 1. Ensure an evaluation for the need of the FC was completed prior to the removal of Resident 417's FC for on 8/14/2024. 2. Ensure Treatment Nurse 1 (TN 1) did not remove Resident 417's FC without a physician's order on 8/14/2024. 3. Ensure TN 1 documented the removal of Resident 417's FC on 8/14/2024. 4. Ensure to monitor for urinary retention (a condition that occurs when the bladder is unable to empty urine) after Resident 417's FC was removed on 8/14/2024. 5. Ensure Registered Nurse 8 (RN 8) used sterile technique (the act of ensuring germs do not enter a resident's body during an invasive procedure) to re-insert Resident 417's FC on 8/14/2024. 6. Ensure between 8/15/2024 to 8/21/2024 Resident 417's FC urine output was measured and documented. 7. Place a securement device/anchor on Resident 158's nephrostomy tube (a tube that lets urine drain from the kidney through an opening in the skin on the back). 8. Place a securement device/anchor on the Resident 150's urinary catheter. These deficient practices had the potential for residents to develop catheter associated urinary tract infections (CAUTI, an infection of the urinary tract caused by an indwelling catheter) and resulted in hospitalization of Resident 417 for evaluation of decreased urinary output. Findings: a.1. During a review of Resident 417's Admission Record, the Admission record indicated the facility admitted the resident on 8/13/2024 and readmitted the resident on 8/22/2024 with diagnoses that included hepatic encephalopathy (a change in your brain function due to injury or disease), acute kidney failure (condition in which the kidneys suddenly cannot filter waste from the blood), and UTI. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 417's Admission Assessment, dated 8/13/2024, the assessment indicated the resident had clear communication and required assistance with mobility, personal hygiene/grooming, bathing, oral hygiene, and dressing. The assessment further indicated the resident arrived at the facility with an indwelling catheter on 8/13/2024. During a review of Resident 417's Physician Orders Summary Report, the report indicated orders for the following: -FC French 16 (a unit of measurement for the diameter of the FC) attached to bedside drainage bag due to obstructive uropathy (condition in which the flow of urine is blocked) every shift, dated 8/14/2024. During a review of Resident 417's Baseline Care Plan (CP) for admitted d 8/13/2024, the CP indicated the resident had impaired urinary elimination related to indwelling catheter use with an initial goal that the resident would have reduced risk for UTI. During an observation and interview on 8/20/2024 at 9:58 a.m., observed Resident 417 lying in bed with a FC. Resident 417 stated his FC was removed and reinserted after admission to the facility. During a concurrent interview and record review on 8/22/2024 at 12:22 p.m., TN 1 reviewed Resident 417's physician orders. TN 1 stated Resident 417 was admitted from the General Acute Care Hospital (GACH) on 8/13/2024 with a FC. TN 1 stated in the morning of 8/14/2024 she removed Resident 417's FC because she believed the resident did not need the FC. TN 1 stated she did not have a physician's order to remove Resident 417's FC. TN 1 stated she did not need an order to remove Resident 417's FC. TN 1 stated Resident 417's family member (FM 1) called later in the day on 8/14/2024 and informed that the resident had a history of urinary retention and needed a FC. TN 1 stated Resident 417's FC was reinserted on 8/14/2024 by RN 8. During an interview on 8/22/2024 at 12:38 p.m., the Assistant Director of Nursing (ADON) stated there must be a physician's order to remove a FC prior to the removal. The ADON stated Resident 417 arrived at the facility with a FC and TN 1 should not have removed the FC without a physician's order. The ADON stated Resident 417's FC was removed too soon, and this should not have happened. The ADON stated TN 1 should have clarified the resident's diagnosis and need for the FC with the physician or RN, but she did not. During a follow up interview on 8/22/2024 at 12:39 p.m., TN 1 stated in the past when residents have arrived from the hospital with a FC, she assumed they did not need the FC and removed it. TN 1 stated when she removed Resident 417's FC, she did not know she needed a physician's order to remove the FC. TN 1 stated now she knows that she should not have removed Resident 417's FC without a physician's order. During an interview on 8/22/2024 at 12:52 p.m., with the ADON and TN 1, the ADON stated it was basic nursing knowledge that any resident device or equipment required a physician's order for removal. TN 1 stated when a FC is removed there should be documentation regarding the removal procedure and monitoring for urinary retention. TN 1 stated the importance of monitoring for urinary retention is to re-insert the FC if the resident does not have urinary output. TN 1 stated she did not document that she removed Resident 417's FC and she did not monitor the resident for urinary retention after removing the FC. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/22/2024 at 1:02 p.m., with Registered Nurse 1 (RN 1), RN 1 stated if a resident arrives from the hospital with a FC, the primary physician must be notified to determine if there is a need for the FC and to obtain an order to remove it. RN 1 stated she arrived at work on 8/14/2024 at about 7:30 a.m. and TN 1 notified her that she had removed Resident 417's FC. RN 1 stated she did not assess the resident, monitor for urinary retention, or check for a physician's order to remove the FC. During a review of the facility policy (P&P) and procedure titled, Urinary Continence and Incontinence - Assessment and Management, last reviewed 4/17/2024, the P&P indicated the staff and practitioner will appropriately screen for, and manage, individuals with urinary incontinence. The physician and staff will provide appropriate services and treatment to prevent urinary tract infections to the extent possible. As part of the initial assessments, the nursing staff and physician will screen for information related to urinary continence. Examples of sources of such information may include residents, family, or a hospital discharge summary describing placement of an indwelling urinary catheter during recent hospitalization . If a resident is admitted from the hospital with a newly placed indwelling catheter, the attending physician and staff will evaluate the potential for removing it, depending on the current condition and rationale for its original placement. During a review of the facility procedure titled, Foley Catheter Removal, last reviewed 4/17/2024, the P&P indicated to verify there is a physician order; to chart the date, time, and volume and color of urine; and to observe the resident for urinary retention. During a review of the facility policy and procedure titled, Charting and Documentation, last reviewed 4/17/2024, the P&P indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The following information will be documented in the resident medical record: treatments or services performed. Documentation of procedures and treatments will include care-specific details, including: the date and time the procedure/treatment was provided, the name and title of the individuals who provided care, how the resident tolerated the procedure, and the signature and title of the individual documenting. During a review of the Licensed Vocational Nurse Job Description, approval date 3/7/2024, indicated the LVN's essential job duties and responsibilities include to perform resident treatments in accordance with physician orders and evaluate and document the resident's response to treatments; to contact the physician for required orders; assure that documentation is timely and completed, and to record fluid intake and output for each patient with an indwelling catheter. The job description further indicated to perform the job successfully, an individual should demonstrate the following competencies: exhibit sound and accurate judgement and have the ability to apply common sense understanding to carry out instructions. a.2. During an interview on 8/22/2024 at 2:28 p.m., FM 1 stated Resident 417 is unable to urinate and requires a FC. FM 1 stated the following occurred while in the facility: -On 8/14/2024 Resident 417's FC was removed and then reinserted after FM 1 called the resident's physician. FM 1 stated Resident 417's FC should not have been removed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 8/14/2024, RN 8 re-inserted Resident 417's FC, RN 8 did not use sterile gloves (individually packaged in pairs that are treated to ensure they are free from microorganisms) or provide a sterile field (a surface considered to be free from microorganisms). FM 1 stated RN 8 used clean gloves (typically packaged in bulk and used for general purposes) for the FC insertion. -On 8/21/2024, Resident 417 was hospitalized because the facility did not accurately monitor and measure Resident 417's urine output which resulted in the need for an evaluation of Resident 417's kidney (organ that remove waste and extra water from the blood as urine) function. During a concurrent interview and record review on 8/22/2024 at 4:23 p.m., with RN 8 reviewed Resident 417's physician orders, Medication Administration Record dated 8/2024, and Treatment Administration Record dated 8/2024. RN 8 stated she re-inserted Resident 417's FC using only clean gloves obtained from inside Resident 417's room. RN 8 stated sterile gloves should be worn for FC insertion to prevent contamination and to prevent infection. RN 8 stated she knew she should use sterile gloves, but she could not find any. RN 8 stated there should also be a sterile drape place under the resident to provide a sterile field during FC insertion, but she did not use a sterile drape because she did not have one. RN 8 further stated residents with foley catheters should have documented measurements of urine output. RN 8 stated it was important to document urine output to determine if the resident is not producing enough urine or if there is a problem with the FC. RN 8 stated between 8/14/2024 and 8/21/2024 there was no documented evidence of Resident 417's measured urine output. RN 8 stated when a resident does not have documented evidence of measured urine output there is the potential that staff would not know the resident had a change of condition and was retaining urine or that there was a problem with the FC. RN 8 stated it was important to identify this change of condition to notify the physician to formulate interventions because there is the potential that the resident may develop urosepsis (a medical emergency that occurs when a UTI spreads to the kidneys). During a concurrent interview and record review on 8/23/2024 at 11 a.m., with the Director of Nursing (DON), the DON reviewed the facility policy and procedures regarding FCs and documentation. The DON stated the facility policy indicated to provide a sterile field and to wear sterile gloves for FC insertion. The DON stated RN 8 told the DON that she did not use a sterile technique when inserting Resident 417's FC. The DON stated the facility had a FC sterile kit in the supply room and RN 8 had the keys to the supply room and should have used the sterile kit. The DON stated it was important to use a sterile technique with FC insertion because there was a risk for infection. The DON further stated FC urine output should be measured and documented every shift. The DON stated on 8/21/24, FM 1 requested the urine output measurement of Resident 417, but there was no documented evidence of the urine output measurements between 8/14/2024 and 8/21/2024. The DON stated because there was no documented measurements of urine output, Resident 417's physician agreed to send the resident to GACH for an evaluation. The DON stated the importance of documentation is so everyone knows what is going on with a resident. The DON stated when everyone is unaware of a resident's status it affects their plan of care. The DON stated the facility policies were not followed when there was no documentation for Resident 417's FC removal, no documented monitoring for retention, RN 8 did not use a sterile technique for FC insertion, and FC urine output was not monitored. The DON stated when the policy was not followed there was a potential for further complications of Resident 417's FC resulting in a decline in the resident with possible further hospitalization s. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility policy and procedure (P&P) titled, Indwelling (Foley) Catheter Insertion, Male Resident, last reviewed 4/17/2024, the P&P indicated the purpose of the procedure was to provide guidelines for the aseptic insertion of an indwelling urinary catheter in a male resident. Aseptic technique is maintained throughout the insertion of a catheter. Equipment and supplies include the catheter insertion tray, which includes some of the following: sterile fenestrated drape with center opening, sterile square drape, and sterile gloves. Steps in the procedure include the following: set up a sterile field and prepare for catheter insertion: open the catheter kit using a sterile technique, apply sterile gloves, open sterile cloth and establish sterile field, remove top tray and place within the sterile field, position square drape over the thighs, and place fenestrated drape. During a review of the facility procedure titled, Foley Catheter Maintenance, last reviewed 4/17/2024, the P&P indicated the objective of the procedure was to maintain a closed drainage system, to prevent bacterial contamination, and to prevent backflow. The procedure indicated to measure urine drainage at the end of each eight-hour shift unless it is needed or ordered more often. During a review of the facility policy and procedure titled, Urinary Incontinence - Clinical Protocol, last reviewed 4/17/2024, the P&P indicated the staff and physician will monitor an individual for complications of indwelling catheters. During a review of the facility policy and procedure titled, Output, Measuring and Recording, last reviewed 4/17/2024, the P&P indicated the purpose of the procedure is to accurately determine the amount of urine that a resident excretes in a 24-hour period. Document the date and time the resident's urine output was measured and recorded. Document the amount in milliliters (a unit of measurement) of the output. During a review of the Registered Nurse Job Description, approval date 8/18/2011, the job description indicated the RN's essential job duties and responsibilities include the skills and knowledge of long-term care patient needs and the ability to deal with problems involving several concrete variables in standardized situations. The job duties also include the RN will assist in providing a clean, safe, and healthy environment for residents. 44376 b. During a review of Resident 158's Admission Record, the Admission Record indicated the facility admitted the resident on 6/28/2024, with diagnoses including sepsis (a serious condition in which the body responds improperly to an infection), acute kidney failure (a sudden and often reversible reduction in kidney function), and artificial opening of urinary tract (a urostomy is a stoma, or opening, in the abdomen that connects the urinary tract to allow urine to drain freely from the body). During a review of Resident 158's History and Physical (H&P), dated 6/28/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 158's Order Summary Report, dated 6/29/2024, the report indicated an order for catheter, secure suprapubic catheter tubing (a thin, flexible rubber or plastic tube that healthcare providers use to drain urine from the urinary bladder when unable to urinate) with anchor every day shift (to minimize dislodging of catheter). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 158's Care Plan (CP) titled, Alteration in urinary elimination and at risk for UTI secondary to use of Foley Catheter (suprapubic cath) and nephrostomy tubes due to obstructive uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow), history of prostate abscess (a localized collection of purulent fluid within the prostate) status post (s/p) transurethral resection of the prostate (TURP, a surgical procedure that removes part of the prostate gland), initiated on 7/6/2024, the CP indicated an intervention of Foley catheter care (keeping the catheter and the area around it clean to prevent infection) every (q) shift or as needed. Maintain proper alignment of foley catheter to promote proper drainage. During a concurrent observation and interview on 8/20/2024, at 11:07 a.m., with Certified Nursing Assistant 3 (CNA 3), inside Resident 158's room, observed the suprapubic catheter of the resident without a securement device or anchor. CNA 3 stated the suprapubic catheter should have a securement device/anchor to prevent pulling out the tube causing trauma and possibly infection. During an interview on 8/23/2024, at 7:10 p.m., with the Director of Nursing (DON), the DON stated the suprapubic catheter should have a securement device or an anchor to prevent pulling of the nephrostomy tube that can cause trauma and bleeding to the site resulting in an infection. During a review of the facility's recent policy (P&P) and procedure titled, Male Catheterization, last reviewed on 4/17/2024, the P&P indicated use of Foley catheter anchors is required. During a review of the facility's recent policy and procedure titled, Indwelling (Foley) Catheter Insertion, Male Resident, last reviewed on 4/17/2024, the P&P indicated to secure catheter and/or bag to resident with approved catheter securement device. c. During a review of Resident 150's Admission Record indicated the facility admitted the resident on 5/22/2024, with diagnoses including sepsis and urinary tract infection. During a review of Resident 150's H&P, dated 5/23/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 150's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others. The MDS indicated the resident was dependent on personal hygiene and had an indwelling catheter (a catheter which is inserted into the bladder, via the urethra and remains in situ to drain urine). During a review of Resident 150's Order Summary Report, dated 5/22/2024, the report indicated an order for [CATHETER] Secure foley catheter tubing with anchor every day shift (to minimize dislodging of catheter). During a review of Resident 150's Interdisciplinary Team (IDT, a group of people from different backgrounds who work together to achieve a common goal)- Catheter Assessment & Care Plan, dated 5/23/2024, it indicated an approach of foley catheter care daily or as ordered. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 8/20/2024, at 10:27 a.m., with Licensed Vocational Nurse 6 (LVN 6), inside Resident 150's room, observed the urinary catheter not secured with an anchor/securement device. LVN 6 stated the resident's catheter was not secured because the securement device/anchor was worn out. LVN 6 stated not anchoring the urinary catheter with a securement device can cause tugging and pulling of the catheter that can result in trauma and skin tear and infection can set in. During an interview on 8/23/2024, at 7:10 p.m., with the DON, the DON stated the suprapubic catheter should have a securement device or an anchor to prevent pulling of the urinary catheter that can result in trauma and bleeding, and infection. During a review of the facility's recent policy and procedure (P&P) titled, Male Catheterization, last reviewed on 4/17/2024, the P&P indicated use of Foley catheter anchors is required. During a review of the facility's recent policy and procedure titled, Indwelling (Foley) Catheter Insertion, Male Resident, last reviewed on 4/17/2024, the P&P indicated to secure catheter and/or bag to resident with approved catheter securement device.

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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. 43988 Based on observation, interview and record review, the facility failed to provide appropriate treatment and services to prevent complications of enteral feeding (EF - a form of nutrition that is delivered into the digestive system as a liquid) for two (2) out of 2 sampled residents (Residents 30 and 367) investigated under the tube feeding care area by failing to ensure Registered Nurse 6 (RN 6) obtained a physician's order for a tube feeding replacement when Jevity 1.2 (a high-protein, fiber-fortified formula that provides complete, balanced nutrition for long- or short-term tube feeding) was unavailable for immediate use by the resident. This deficient practice had the potential to place Residents 30 and 367 at risk for complications of enteral feeding such as diarrhea (loose, watery stools) or vomiting which may lead to dehydration (loss or removal of water). Findings: a.During a review of Resident 30's Admission Record, the Admission Record indicated the facility admitted the resident on 6/6/2014 and readmitted the resident on 6/4/2024 with diagnoses including but not limited to dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), adult failure to thrive (a condition that happens when an older adult has a loss of appetite, eats and drinks less than usual, loses weight, and is less active than normal), and gastrostomy status (a surgical procedure used to insert a tube, through the abdomen and into the stomach to provide a route for tube feeding. During a review of Resident 30's History and Physical (H&P) dated 6/5/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 30's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 8/13/2024, the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and require total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 30 was receiving tube feeding. During a review of Resident 30's Order Summary Report6/17/2024, the report indicated the following orders: 6/17/2024 Enteral Feed Order[Enteral feeding: Jevity 1.2 at 65 milliliters per hour (ml/hr - a unit of measurement) for 20 hours via pump to provide 1300 ml/1560 kilocalories (Kcal - a unit of measurement) per day. 6/4/2024 Enteral Feed Order [Enteral] feeding: Turn pump on at 12 p.m. and turn off at 8 a.m. (or until dose is completed). (continued on next page)

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	555686	A. Building B. Wing	08/23/2024

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Studio City Rehabilitation Center	11429 Ventura Blvd Studio City, CA 91604

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 8/20/2024 at 10:30 a.m., inside Resident 30's room with Licensed Vocational Nurse 3 (LVN 3), observed an EF bag of Fibersource HN (a type of feeding formula formulated with fiber to meet the nutritional needs for tube feeding patients with normal or elevated calorie and/or protein requirements) hanging on the pole the resident's bedside. The enteral feeding bag tubing was connected to the resident's gastrostomy tube (a tube inserted through the wall of the abdomen directly into the stomach) and was delivering the EF via pump with infusion rate at 65 milliliters per hour (ml/hr - a unit of measurement). LVN 3 verified Resident 30's was receiving Fibersource HN. During a concurrent interview and record review on 8/20/2024 at 12:30 p.m., with LVN 3, reviewed Resident 30's physician's orders. with LVN 3. LVN 3 verified Resident 30's EF formula order was Jevity 1.2 and the bag hanging and currently infusing at 65 ml/hr was Fibersource HN. LVN 3 stated she did not know the reason why the resident was receiving Fibersource HN instead of Jevity 1.2. LVN 3 stated there was no report from the night shift nurse that Jevity 1.2 was out of stock. LVN 3 stated if an EF is out of stock, the licensed nurse should notify the physician and obtain an order to use another feeding formula while waiting for Jevity 1.2 to be delivered to ensure the resident was getting the correct type of feeding and their caloric needs are being met. During a concurrent observation and interview on 8/20/2024 at 12:45 p.m., with the Director of Staff Development (DSD), observed the Enteral Room (a locked closet where all the EF formulas in the facility are stored) and the DSD stated there is no Jevity 1.2 stocked in the room. The DSD stated she is not aware if the facility had run out of of Jevity 1.2. The DSD stated the Central Supply Supervisor (CSS) is responsible for ordering EF formulas. During an interview on 8/20/2024 at 1:18 p.m., with the CSS, the CSS stated Jevity 1.2 is on back order since 8/16/2024 and the supplier does not have a projected date of when it will be back on stock. During an interview on 8/23/2024 at 7:20 a.m., with Registered Nurse 3 (RN 3), RN 3 stated that he used Fibersource HN as a substitute for Jevity 1.2 because Jevity 1.2 is out of stock. RN 3 stated that he should have called the physician to obtain an order to change the feeding formula to ensure Resident 30 was getting the type of feeding to address the resident's caloric needs. RN 3 stated he did not notify or gave a hand off report that Jevity 1.2 was out of stock. During an interview on 8/23/2024 at 7:45 p.m., with the Director of Nursing (DON), the DON stated all EF formulas should have a physician's order. The DON stated RN 3 should have notified the physician when the facility ran out of Jevity 1.2 supply and obtain an order to change the formula until Jevity 1.2 was available to ensure Resident 30 was receiving the appropriate feeding in meeting the resident's caloric needs. During a review of the facility's policy and procedure (P&P) titled, Enteral Feeding Monitoring, last reviewed 4/17/2024, the P&P indicated the facility will ensure that the total enteral feeding prescribed is administered as ordered. The policy indicated licensed nurse will check physician's order for formula type, rate, hours and total to be delivered. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Enteral Tube Feeding via Continuous Pump, last reviewed 4/17/2024, the P&P indicated to verify that there is a physician's order for the feeding. The policy indicated to check the enteral nutrition label against the order before administration and check the following information such as the type of formula and the rate of administration. b. During a review of Resident 367' s Admission Record, the Admission Record indicated the facility admitted the resident on 5/22/2024 and readmitted the resident on 8/8/2024 with diagnoses including but not limited to dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), adult failure to thrive (a condition that happens when an older adult has a loss of appetite, eats and drinks less than usual, loses weight, and is less active than normal), and gastrostomy status (a surgical procedure used to insert a tube, through the abdomen and into the stomach to provide a route for tube feeding. During a review of Resident 367's History and Physical (H&P) dated 8/8/2024, the H&P indicated the resident did not indicate capacity to understand and make decisions. During a review of Resident 367's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 8/15/2024, the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required substantial/maximal assistance with mobility and total assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 30 was receiving tube feeding. During a review of Resident 367's Order Summary Report dated 8/15/2024, the report indicated the following order: Enteral feeding: Jevity 1.2 at 70 milliliters per hour (ml/hr - a unit of measurement) per hour for 20 hours via pump to provide 1400 ml/1680 kilocalories (kcal - a unit of measurement) per day. Enteral: Turn pump on at 12 p.m. and turn off at 8 a.m. (or until dose is completed). During a concurrent observation and interview on 8/20/2024 at 10:30 a.m., inside Resident 367's room with Licensed Vocational Nurse 3 (LVN 3), observed an s EF bag of Fibersource HN (a type of feeding formula formulated with fiber to meet the nutritional needs for tube feeding patients with normal or elevated calorie and/or protein requirements) hanging on the pole at the resident's bedside. The enteral feeding bag tubing was connected to the resident's gastrostomy tube (a tube inserted through the wall of the abdomen directly into the stomach) and was delivering the EF via pump with infusion rate at 60 milliliters per hour (ml/hr - a unit of measurement). LVN 3 verified Resident 367 was receiving Fibersource HN. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 8/20/2024 at 12:30 p.m., with LVN 3, reviewed Resident 367's physician's orders. LVN 3 verified Resident 367's EF formula order was Jevity 1.2 at 70 ml/hr and the bag hanging and currently infusing at 60 ml/hr is Fibersource HN. LVN 3 stated she did not know the reason why the resident was receiving Fibersource HN instead of Jevity 1.2. LVN 3 stated there was no report from the night shift nurse that Jevity 1.2 was out of stock. LVN 3 stated if an EF is out of stock, the licensed nurse should notify the physician and obtain an order to use another feeding formula while waiting for Jevity 1.2 to be delivered to ensure the resident was getting the correct type of feeding and their caloric needs are being met. During a concurrent observation and interview on 8/20/2024 at 12:45 p.m., with the Director of Staff Development (DSD), observed the Enteral Room (a locked closet where all the EF formulas in the facility are stored) and the DSD stated there is no Jevity 1.2 stocked in the room. The DSD stated she is not aware if the facility had run out of of Jevity 1.2. The DSD stated the Central Supply Supervisor (CSS) is responsible for ordering EF formulas. During an interview on 8/20/2024 at 1:18 p.m., with the CSS, the CSS stated Jevity 1.2 is on back order since 8/16/2024 and the supplier does not have a projected date of when it will be back on stock. During an interview on 8/23/2024 at 7:20 a.m., with Registered Nurse 3 (RN 3), RN 3 stated that he used Fibersource HN as a substitute for Jevity 1.2 because Jevity 1.2 is out of stock. RN 3 stated that he should have called the physician to obtain an order to change the feeding formula to ensure Resident 367 was getting the type of feeding to address the resident's caloric needs. RN 3 stated he did not notify or gave a hand off report that Jevity 1.2 was out of stock. During an interview on 8/23/2024 at 7:45 p.m., with the Director of Nursing (DON), the DON stated all EF formulas should have a physician's order. The DON stated RN 3 should have notified the physician when the facility ran out of Jevity 1.2 supply and obtain an order to change the formula until Jevity 1.2 was available to ensure Resident 367 was receiving the appropriate feeding in meeting the resident's caloric needs. During a review of the facility's policy and procedure (P&P) titled, Enteral Feeding Monitoring, last reviewed 4/17/2024, the P&P indicated the facility will ensure that the total enteral feeding prescribed is administered as ordered. The policy indicated licensed nurse will check physician's order for formula type, rate, hours and total to be delivered. During a review of the facility's policy and procedure titled, Enteral Tube Feeding via Continuous Pump, last reviewed 4/17/2024, the P&P indicated to verify that there is a physician's order for the feeding. The policy indicated to check the enteral nutrition label against the order before administration and check the following information such as the type of formula and the rate of administration.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 43988 Based on observation, interview and record review, the facility failed to administer parenteral fluids (the intravenous administration of medication) consistent with professional standards of practice for one (1) out of 1 sampled resident (Resident 104) during random observation of residents with intravenous (IV) catheter (a thin, flexible tube that is inserted into a vein to draw blood and give treatments including IV fluids, drugs, or blood transfusions) by: 1. Failing to indicate the insertion date and the licensed nurse's initials on the peripheral intravenous line (PIV - a soft, flexible tube placed inside a vein, usually in the hand or arm to give a person medicine or fluids) dressing. 2. Failing to place a sterile injection cap over the injection port of the PIV line. These deficient practices placed the residents at risk for developing complications such as inflammation of the vein and infection. Findings: During a review of Resident 104' Admission Record, the Admission Record indicated the facility admitted the resident on 8/24/2020 and readmitted the resident on 3/14/2024 with diagnoses including but not limited to chronic respiratory failure (a long-term condition in which your lungs have a hard time loading your blood with oxygen and can leave you with low oxygen), paraplegia (refers to total paralysis on both sides of the body), and anoxic brain damage (a condition that refers to an injury to the brain due to complete loss of oxygen). During a review of Resident 104's History and Physical (H&P) dated 3/15/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 104's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 8/4/2024, the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 104 had impairment on both upper and lower extremities. During a review of Resident 104's physician's orders dated 8/17/2024 indicated the following: Peripheral site care: every 96 hours for site care, restart IV and subcutaneous site (additional physician's order required for insertion of IV catheter into lower extremities) and as needed for complications may extend IV site for poor venous access if no complications are present. Change dressing with site change and as needed. May insert peripheral IV in lower extremities if unable to get access in upper extremities. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 8/20/2024 at 1:20 p.m., inside Resident 104's room with Licensed Vocational Nurse 4 (LVN 4), observed the resident with a PIV on the right foot. The PIV line dressing did not indicate the insertion date and the initials of the licensed nurse who inserted the PIV. LVN 4 stated the PIV line dressing should indicate the insertion date and initials of the licensed nurse (LN) so the LNs would know when the next PIV and dressing change is due and to prevent complications such as swelling and infection. During a concurrent observation and interview on 8/20/2024 at 1:45 p.m., inside Resident 104's room, with Registered Nurse 3 (RN 3), observed the resident's PIV line on the right foot. The PIV line dressing did not indicate the insertion date and the initials of the licensed nurse who inserted the PIV. There was no injection cap placed over the injection port of the PIV catheter. RN 3 stated the injection port should have a sterile injection cap over the injection port and the PIV line dressing should indicate the insertion date and initials of the LN so the LNs would know when the next PIV and dressing change is due and to prevent complications such as swelling and infection. During a review of the facility's policy and procedure (P&P) titled, Peripheral Venous Catheter Insertion, last reviewed 4/17/2024, indicated PIV catheter sites will be changed every 96 hours or more frequently if catheter related complications develop and write the date, time, and initials on the dressing label.

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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** 44376 Based on observation, interview, and record review the facility failed to ensure residents receive the necessary respiratory care and services that is in accordance with professional standards of practice by failing to place a fenestrated gauze (a type of wound care product that has cuts, or fenestrations, cut through the entire thickness of the material to allow exudate to drain from a wound) under the flange (is the part of the tracheostomy tube [a metal or plastic tube placed in surgically created opening in the windpipe to keep it open] that extends from the outer part of the tracheostomy [an opening surgically created through the neck into the windpipe] and has holes to attach the tracheostomy tube tie) around the tracheostomy opening for two out of three sampled resident (Residents 468 and 112) investigated during review of respiratory care area The deficient practice had a potential to cause Residents 468 and 112 to develop pressure injury (areas of skin damage caused by prolonged or severe pressure on the skin and underlying soft tissue) and infection on the tracheostomy site. Findings: a. During a review of Resident 468's Admission Record, then Admission Record indicated the facility admitted the resident on 8/14/2024, with diagnoses including dependence on respirator (if a resident is unable to wean off a ventilator and breathe independently), tracheostomy, and pneumonia (an infection that affects one or both lungs). During a review of Resident 468's History and Physical (H&P), dated 8/15/2024, the H&P indicated the resident is incapacitated and requires visit for safety and the resident did not have the capacity to make decisions. During a review of Resident 468's Order Summary Report, dated 8/15/2024, the report indicated an order to change dressing as needed for when soiled or pulled out. During a concurrent observation and interview on 8/20/2024, at 10:25 a.m., with Respiratory Therapist 1 (RT 1), inside Resident 468's room, observed the resident's tracheostomy tube without a fenestrated gauze under the flange. RT 1 stated there should have been a fenestrated gauze underneath the tracheostomy flange to protect the skin on the tracheostomy site from breaking down. During an interview on 8/23/2024, at 7:10 p.m., with the Director of Nursing (DON), the DON stated staff should ensure there is a fenestrated gauze underneath Resident 468's tracheostomy flange to prevent infection and pressure injury (a breakdown of skin integrity due to pressure) on the tracheostomy site. b. During a review of Resident 112's Admission Record, the admission record indicated the facility admitted the resident on 3/20/2021, and readmitted the resident on 6/28/2024, with diagnoses including chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body) and tracheostomy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 112's H&P, dated 6/28/2024, the H&P indicated the incapacitated resident requires visit for safety. During a review of Resident 112's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others. The MDS indicated the resident was dependent on personal hygiene and was on tracheostomy care. During a review of Resident 112's Care Plan (CP) titled, Excoriation Trach: Resident is at risk for excoriation around the trach stoma site secondary to caustic secretion leakage from the tracheostomy, initiated on 4/9/2021, the CP indicated an intervention to keep dressing clean and dry at stoma site, keep trach/stoma site clean and dry, and observe for signs or symptoms of infection i.e. redness at site, drainage, odor, elevated temp, coughing, rapid pulse or congestion and notify MD as indicated. During a concurrent observation and interview on 8/20/2024, at 9:48 a.m., with Respiratory Therapist 2 (RT 2), inside Resident 112's room, observed the resident's tracheostomy tube without a fenestrated gauze under the flange. RT 1 stated there should have been a fenestrated gauze underneath the tracheostomy flange to protect the skin on the tracheostomy site from breaking down. During an interview on 8/23/2024, at 7:10 p.m., with the Director of Nursing (DON), the DON stated staff should ensure there is a fenestrated gauze underneath Resident 468's tracheostomy flange to prevent infection and pressure injury (a breakdown of skin integrity due to pressure) on the tracheostomy site. During a review of the facility's recent policy and procedure (P&P) titled, Tracheostomy Care (a routine procedure that involves keeping a tracheostomy [trach] tube and the surrounding are clean to prevent bacteria from entering the lungs and trachea), last reviewed on 4/17/2024, the P&P indicated the purpose of this procedure is to guide tracheostomy care and cleaning of reusable tracheostomy cannulas. Site and Stoma (a surgically created opening) Care: 7. Apply a fenestrated gauze pad around the insertion site. The facility must ensure that a resident that needs respiratory care including tracheostomy care and tracheal suctioning, is provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 43455 Based on interview and record review the facility failed to: 1. Account for five doses of Controlled Medications (also known as Controlled Drug and Controlled Substance [CM, CD, CS]- medications which have a potential for abuse and may also lead to physical or psychological dependence) for Residents 30, 42, 60, 123, and 317 in one of five inspected medication carts (Medication Cart Station 1) 2. Document and dispose (remove or destroy) an Ativan (a CM) vial for Resident 143 in the presence of two witnesses, in one of three inspected medication rooms (Medication Room Subacute.) As a result, control and accountability of CMs did not follow state and federal regulations and facility policy and procedures. These deficient practices increased the opportunity for CM diversion (the transfer of a controlled medication or other medication from a lawful to an unlawful channel of distribution or use), the risk that Residents 30, 42, 60, 123, and 317 could have delayed medication treatment and continuity of care due to lack of availability of the CM, and the potential for accidental exposure to harmful medications to all residents, possibly leading to physical and psychosocial harm and hospitalization . Findings: During an observation on [DATE] at 12:30 PM in Medication Room Subacute, in the presence of Licensed Vocational Nurse (LVN) 4 and Registered Nurse (RN) 4, the Antibiotic or Controlled Drug Record accountability log was found without the date and signatures of the licensed staff (RN or Director of Nursing [DON] and Consultant Pharmacist [CP]) involved in the disposition of 22.5 milliliter ([ml] - a unit of measure of volume) remaining in the Ativan vial for Resident 143. During a concurrent interview, in the presence of LVN 4, RN 4 stated that RN 4 disposed 22.5 ml remaining in the Ativan vial for Resident 143 on [DATE] in the pharmaceutical bin located in the Medication Room Subacute because the Ativan vial was expired, and forgot to hand over the vial along with the Antibiotic or Controlled Drug Record accountability log to the DON for disposal and documentation with the CP. RN 4 stated that usually RN 4 hands over the CM pending disposal to the DON along with the Antibiotic or Controlled Drug Record accountability log so that the DON disposes in the presence of the CP. RN 4 stated that RN 4 overlooked that the Ativan was a CM and failed to follow the CM disposal policy compromising accountability of CM. RN 4 stated that failure to follow CM disposal policy and process can create opportunity for diversion, and harm staff and residents by exposing them to harmful substances. During an observation on [DATE] at 2:06 PM, with LVN 3, in Medication Cart Station 1, there was a discrepancy in the count between the Antibiotic or Controlled Drug Record accountability log and the amount of medication remaining in the medication bubble pack (medication packaging system that contains individual doses of medication per bubble) for the following residents: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. One dose of hydrocodone with acetaminophen (a combination CM used for pain) ,d+[DATE] milligram ([mg] - a unit of measure of mass) tablet was missing from the medication bubble pack compared to the count indicated on the Antibiotic or Controlled Drug Record accountability log for Resident 30. The Antibiotic or Controlled Drug Record accountability log for hydrocodone with acetaminophen indicated the medication bubble pack should have contained a total of 13 hydrocodone with acetaminophen ,d+[DATE] mg tablets, after the last administration of hydrocodone with acetaminophen ,d+[DATE] mg tablet documented/signed-off on [DATE] at 11:39 PM, however the medication bubble pack contained 12 hydrocodone with acetaminophen ,d+[DATE] mg tablets and contained no other documentation of subsequent administrations. 2. One dose of lacosamide (a CM used for seizure [bursts of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle movements, behaviors, sensations, or states of awareness) 100 mg tablet was missing from the medication bubble pack compared to the count indicated on the Antibiotic or Controlled Drug Record accountability log for Resident 42. The Antibiotic or Controlled Drug Record accountability log for lacosamide indicated the medication bubble pack should have contained a total of 13 lacosamide 100 mg tablets, after the last administration of lacosamide 100 mg tablet documented/signed-off on [DATE] at 5:35 PM, however the medication bubble pack contained 12 lacosamide 100 mg tablets and contained no other documentation of subsequent administrations. 3. One dose of Ativan (a CM used for anxiety) 0.25 mg tablet was missing from the medication bubble pack compared to the count indicated on the Antibiotic or Controlled Drug Record accountability log for Resident 60. The Antibiotic or Controlled Drug Record accountability log for Ativan indicated the medication bubble pack should have contained a total of 24 Ativan 0.25 mg tablets, after the last administration of Ativan 0.25 mg tablet documented/signed-off on [DATE] at 8:05 PM, however the medication bubble pack contained 23 Ativan 0.25 mg tablets and contained no other documentation of subsequent administrations. 4. One dose of Ativan 0.5 mg tablet was missing from the medication bubble pack compared to the count indicated on the Antibiotic or Controlled Drug Record accountability log for Resident 123. The Antibiotic or Controlled Drug Record accountability log for Ativan indicated the medication bubble pack should have contained a total of 7 Ativan 0.5 mg tablets, after the last administration of Ativan 0.5 mg tablet documented/signed-off on [DATE] at 5:11 PM, however the medication bubble pack contained 6 Ativan 0.5 mg tablets and contained no other documentation of subsequent administrations. 5. One dose of viberzi (a CM used for Irritable Bowel Syndrome [IBS] - a condition that causes stomach cramps, bloating, diarrhea and constipation) 75 mg tablet was missing from the medication bubble pack compared to the count indicated on the Antibiotic or Controlled Drug Record accountability log for Resident 317. The Antibiotic or Controlled Drug Record accountability log for viberzi indicated the medication bubble pack should have contained a total of 5 viberzi 75 mg tablets, after the last administration of diphenoxylate with viberzi 75 mg tablet documented/signed-off on [DATE] at 6:05 PM, however the medication bubble pack contained 4 viberzi 75 mg tablets and contained no other documentation of subsequent administrations. (continued on next page)

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Studio City Rehabilitation Center	11429 Ventura Blvd Studio City, CA 91604

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview, LVN 3 stated LVN 3 administered hydrocodone with acetaminophen , d+[DATE] mg tablet to Resident 30, lacosamide 100 mg tablet to Resident 42, Ativan 0.5 mg tablets to Resident 60 and 123, and viberzi 75 mg tablet to Resident 317 that morning and forgot to sign the Antibiotic or Controlled Drug Record accountability logs. LVN 3 stated LVN 3 failed to follow the facility's policy of signing each CM dose on the Antibiotic or Controlled Drug Record accountability log after preparing the dose for the resident. LVN stated LVN 3 understood it was important to sign each dose once administered to ensure accountability, prevention of CM diversion, and accidental exposures of harmful substances to residents. LVN 3 stated if documentation was not accurate then it can lead to medication error by overdosing (administering more than the prescribed dose) leading to stoppage of breathing, hospitalization and possibly death for Residents 30, 42, 60, 123 and 317. During an interview on [DATE] at 10:19 AM, with the DON, the DON stated that the Antibiotic or Controlled Drug Record accountability logs should be dated and signed by the DON or RN and CP when disposing of CMs. The DON stated that the Antibiotic or Controlled Drug Record accountability log for Ativan 22.5 ml disposal for Resident 143 missing the date and signatures of RN/DON and CP. The DON stated that proper CM disposition was important to prevent diversion and prevent harm to residents by the accidental use and administration of harmful substances. The DON stated that RN 4 failed to follow CM disposal policy and properly document the disposal of Ativan for Resident 143. During the same interview, the DON stated LVN 3 failed to follow facility policy of documenting the preparation of CM immediately on the Antibiotic or Controlled Drug Record accountability log for Resident 30, 42, 60, 123 and 317. The DON stated not documenting the Antibiotic or Controlled Drug Record timely can lead to accountability failures, CM diversion, inaccurate clinical records, overdose, and accidental use of harmful substances causing adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) to residents such as respiratory depression (stoppage of breathing) and hospitalization , negatively impacting their health and wellbeing. During a review of Resident 30's Admission Record (a document containing demographic and diagnostic information,) dated [DATE], the Admission Record indicated Resident 30 was originally admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis including respiratory (related to breathing) failure, injury of the head, fracture (breakage) of left humerus (the long bone in the upper arm) and polyneuropathy (a condition that affects many nerves in the body causing pain.) During a review of Resident 30's Order Summary Report, dated [DATE], the report indicated Resident 30 was prescribed hydrocodone with acetaminophen ,d+[DATE] mg to give 1 tablet via Gastrostomy tube ([G-tube]- a tube inserted in the stomach used to provide nutrition and medications) every 4 hours as needed for moderate to severe pain (pain level ,d+[DATE] out of 10,) starting [DATE]. During a review of Resident 30' s (Medication Administration Record ([MAR] - a record of mediations administered to residents), for [DATE], the MAR indicated Resident 30 was prescribed hydrocodone with acetaminophen ,d+[DATE] mg to give 1 tablet via G-tube every 4 hours as needed for moderate to severe pain (pain level ,d+[DATE] out of 10,) and was administered a dose on [DATE] at 1:21 PM. During a review of Resident 42's Admission Record, dated [DATE], the Admission Record indicated Resident 42 was originally admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis including seizure. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 42's Order Summary Report, dated [DATE], the report indicated Resident 42 was prescribed lacosamide 100 mg to give 1 tablet by mouth two times a day for seizure, starting [DATE]. During a review of Resident 42's MAR for [DATE], the MAR indicated Resident 42 was prescribed lacosamide 100 mg to give 1 tablet by mouth two times a day for seizure, at 9 AM and 5 PM. During a review of Resident 60's Admission Record, dated [DATE], the Admission Record indicated Resident 60 was originally admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis including anxiety. During a review of Resident 60's Order Summary Report, dated [DATE], the report indicated Resident 60 was prescribed Ativan 0.25 mg to give via G-tube every 12 hours for anxiety, starting [DATE]. During a review of Resident 60's MAR for [DATE], the MAR indicated Resident 60 was prescribed Ativan 0. 25 mg to give via G-tube every 12 hours for anxiety, at 9 AM and 9 PM. During a review of Resident 123's Admission Record, dated [DATE], the Admission Record indicated Resident 123 was originally admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis including anxiety. During a review of Resident 123's Order Summary Report, dated [DATE], the report indicated Resident 123 was prescribed Ativan 0.5 mg to give 1 tablet by mouth two times a day for anxiety, starting [DATE]. During a review of Resident 123's MAR for [DATE], the MAR indicated Resident 42 was prescribed Ativan 0. 5 mg to give 1 tablet by mouth two times a day for anxiety, at 9 AM and 5 PM. During a review of Resident 317's Admission Record, dated [DATE], the Admission Record indicated Resident 317 was originally admitted to the facility on [DATE] with a diagnosis including dysphagia (difficulty swallowing.) During a review of Resident 317's Order Summary Report, dated [DATE], the report indicated Resident 317 was prescribed viberzi 75 mg to give 1 tablet by mouth two times a day for IBS, starting [DATE]. During a review of Resident 317's MAR for [DATE], the MAR indicated Resident 317 was prescribed lacosamide 100 mg to give 1 tablet by mouth two times a day for seizure, at 9 AM and 5 PM. Review of the policy and procedures (P&P), titled Controlled Medications, dated [DATE], the P&P indicated that Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility, in accordance with federal and state laws and regulations. A. The DON and the CP maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. When a controlled mediation is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the MAR: a. Date and time of administration b. Amount administered c. Signature of the nurse administering the dose on the accountability record at the time the medication is removed from the supply. D. When a dose of a CM is removed from the container for administration but refused by the resident or not given for any reason .It must be destroyed according to facility policy in the presence of two licensed nurses and the disposal documented on the accountability record .The same process applies to the disposal of unused partial tablets and unused portions of single dose ampules. Review of the P&P titled Controlled Medication Storage, dated [DATE], the P&P indicated Medications included in the DEA classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility, in accordance with federal and state laws and regulations. A. The DON and the CP maintain the facility's compliance with federal and state laws and regulations in the handling of CMs. H. CM remaining in the facility after the order has been discontinued are retained in the facility in a securely double locked area with restricted access until destroyed by the facility's DON or a RN employed by the facility and a pharmacist. Review of the P&P, titled Controlled Medication Disposal, dated [DATE], the P&P indicated Medications included in the DEA classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility, in accordance with federal and state laws and regulations. A. The DON and the CP maintain the facility's compliance with federal and state laws and regulations in the handling of CMs. B. When a dose of a CM is removed from the container for administration but refused by the resident or not given for any reason .It must be destroyed according to facility policy in the presence of two licensed nurses and the disposal documented on the accountability record .The same process applies to the disposal of unused partial tablets and unused portions of single dose ampules and doses of CS wasted for any reason. D. Schedule II-V CS remaining in the facility after a resident has been discharged , or the order discontinued, are disposed of in the facility by the DON or designated facility RN in conjunction with the pharmacist.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on interview and record review, the facility failed to ensure the Consultant Pharmacist's (CP) recommendation for June 2024 Medication Regimen Review ([MRR] - a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) note was reviewed, addressed or carried out as per facility policy and procedure for one of five sampled residents (Resident 56). The deficient practice increased the risk of receiving medication that was not optimal for Resident 56's medical condition, that would not maintain the resident's highest level of physical, mental and psychosocial well-being and/or increase the risk of side effects (a type of adverse effects [unwanted, uncomfortable, or dangerous effects that a drug may have]) from the medication therapy. Findings: During a review of Resident 56's Admission Record (a document containing demographic and diagnostic information,) dated 8/21/24, indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Gastro-Esophageal Reflux Disease ([GERD] - a condition where there is a backward flow of stomach acid into the tube that connects the mouth to the stomach.) During a review of Resident 56's Order Summary Report, dated 8/21/24, indicated Resident 56 was prescribed pantoprazole (a proton pump inhibitor [PPI] medication used for GERD) 40 milligrams ([mg] - unit of measure of mass) to give 1 tablet orally once a day AC (before) breakfast for GERD, starting 10/12/23. During a review of Resident 56's Medication Administration Record ([MAR] - a document of the medications administered to a resident that is part of the resident's permanent medical record,) for August 2024, the MAR indicated Resident 56 was prescribed pantoprazole 40 mg to give 1 tablet orally once a day AC breakfast for GERD, at 6:30 AM. During a review of the MRR note by the CP for Resident 56 on 8/22/24 at 10:17 AM, the note was dated 6/26/24 and indicated Resident has been taking pantoprazole 40 mg daily for GERD since 10/13/2023. Long term use of PPIs may increase the risk of Clostridioides difficile ([C.diff] - a bacteria that causes diarrhea,) osteoporosis (a condition where bones are weakened, become brittle and break), hypomagnesemia (having low magnesium levels in the blood,) and Chronic Kidney Disease ([CKD]- a condition where the kidneys [organ that filters waste] are damaged.) Recommendation is to re-evaluate use after 8 to 12 weeks to reduce risk of long term side effects. Please evaluate Risks/Benefits of pantoprazole for this patient. If appropriate, may we consider dose reduction to pantoprazole 20 mg QD at this time? YES___NO___ Thank you. The document did not contain a response from a physician and was not signed or dated by a physician. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/22/24 at 11:29 AM, with Registered Nurse (RN) 9, RN 9 stated RN 9 was unable to locate a signed response from the physician for the pantoprazole MRR note by the CP for Resident 56. RN 9 stated that the MRR notes should be addressed within 30 days from the date written and that the pantoprazole note for Resident 56 was not documented timely. RN 9 stated that RN 9 contacted the physician prior to the interview and obtained a telephone order addressing the CP MRR note for Resident 56. RN 9 stated continuing pantoprazole longer than necessary increases the risk of hypomagnesemia, C. diff, osteoporosis and CKD for Resident 56., During an interview on 8/23/24 at 10:19 AM, with the Director of Nursing (DON,) the DON stated per facility policy the MRR irregularity notes by the CP needed to be reviewed and documented within 30 days of the written report. The DON stated it was important to review the irregularities timely to ensure residents were receiving treatment that was optimal for their condition, to maintain their highest level of well-being, and be free from unnecessary medications and harm from their side effects. The DON stated the facility and physician failed to timely review and address the CP MRR note written on 6/26/24 for the continued use of pantoprazole and failed to timely document a clinical rationale for continuing the pantoprazole 40 mg daily, as originally prescribed for GERD on 10/13/23 for Resident 56. Review of facility policy and procedure (P&P) titled Medication Regimen Review (Monthly Review), dated December 2016, the policy indicated: The consultant pharmacist performs a comprehensive MRR at least monthly. The MRR includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy. E. Recommendations are acted upon and documented by the facility staff and or the prescriber. 1) Physician accepts and acts upon suggestion or rejects and provides an explanation for disagreeing by the next physician visit. Review of facility P&P titled Consultant Pharmacist Services Provider Requirements, dated October 2017, the policy indicated: 5. Identifying one or more current medication references to facilitate the identification of medications and information on contraindications, side effects and/or adverse effects, dosage levels and other pertinent information E. Activities that the consultant pharmacist or off-site pharmacist performs includes, but is not limited to: a. A residents drug regime must be free from unnecessary drugs. An unnecessary drug is any drug when used in: i. excessive dose ii. excessive duration.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on interview and record review, the facility failed to ensure one of five sampled residents (Residents 126) was free from unnecessary medications by not implementing adequate monitoring for Melatonin (a medication used to regulate circadian rhythm [body's sleep and wake cycle]). As a result, Resident 126 was not monitored for hours of sleep and for the effectiveness and side effects (also known as adverse effects - unwanted, uncomfortable, or dangerous effects that a drug may have) of Melatonin since 7/8/24. This deficient practice had the potential to cause Resident 126 to receive suboptimal (less than the highest standard or quality) care, and inability to assess the effectiveness of Melatonin for sleep, leading to the use of unnecessary medications causing potential side effects and negatively impacting their physical, mental, and psychosocial well-being. Cross reference F656 Findings: During a review of Resident 126's Admission Record (a document containing demographic and diagnostic information,) dated 8/22/24, the Admission Record indicated Resident 126 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including depression (a mental health condition that can cause feelings of sadness, loss of interest in activities and difficulty sleeping.) During a review of Resident 126's Order Summary Report, dated 8/22/24, the report indicated Resident 126 was prescribed Melatonin 5 milligram ([mg] - a unit of measure of mass) to give one tablet by mouth at bedtime for supplement, starting 3/30/22. During a review of Resident 126's Medication Administration Record ([MAR] - a record of mediations administered to residents,) for August 2024, the MAR indicated Resident 126 was prescribed Melatonin 5 mg to give one tablet by mouth at bedtime for supplement, at 9 PM. During a review of Resident 126's Care Plan, initiated 7/8/24, the Care Plan indicated a goal of sleep of 6 hours per night. During a review of the facility's Consultant Pharmacist's (CP) Medication Regimen Review ([MRR] - a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication,) document review dated 6/26/24, the document indicated Resident has been on order for Melatonin 5 mg qhs (at bedtime) for supplement. Please consider changing the indication of Melatonin use to: 'for supplement to regulate Circadian rhythm.' Also consider monitor for 'hours of sleep qPM (at evening) and qNOC (at bedtime) shifts' to facilitate drug therapy monitoring. The column marked 'Follow-Through, was empty and did not contain any documentation, dates, or signatures for the review of the CP's recommendations. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 126's Minimum Data Set (MDS - a comprehensive resident assessment tool), dated 7/6/24, the MDS indicated resident was severely impaired with cognition (mental action or process of acquiring knowledge and understanding) based on the results of the Brief Interview for Mental Status ([BIMS] - a mandatory tool used to screen and identify cognitive condition of residents upon admission into a long-term care facility,) and that symptom presence and frequency for trouble falling or staying asleep, or sleeping too much was not marked. During an interview on 8/22/24 at 1:14 PM, with the Director of Nursing (DON,) the DON stated that Resident 126's care plan dated 7/8/24 indicated a goal of sleep of 6 hours per night. The DON stated after a thorough search of Resident 126's clinical record the DON was unable to locate documentation for monitoring the number of hours of sleep. The DON stated without monitoring hours of sleep it was unknown if non-pharmacological (that do not involve medications or drugs) interventions (therapies) and/or Melatonin were effective in reaching the goal of 6 hours of sleep and when to make changes to medications such as lowering the dose or discontinuing, leading to the use of unnecessary medications for Resident 126. The DON stated that the indication for Melatonin was also not updated to specify use for regulating circadian rhythm. The DON stated that facility failed to monitor for hours of sleep and indicate specific use of Melatonin, and that it will be immediately initiated for Resident 126. Review of the facility's Policy & Procedures, titled Section A Resident Assessment, dated 4/2014, the P&P indicated: 14. Resident Rights - Care Planning B. The resident has the right to receive the services and/or items included in the plan of care. Review of facility P&P titled Consultant Pharmacist Services Provider Requirements, dated October 2017, the policy indicated: 5. Identifying one or more current medication references to facilitate the identification of medications and information on contraindications, side effects and/or adverse effects, dosage levels and other pertinent information E. Activities that the consultant pharmacist or off-site pharmacist performs includes, but is not limited to: a. A residents drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in: iii. without adequate monitoring iv. without adequate indication for its use.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five percent (%). Two medication errors out of 31 total opportunities contributed to an overall medication error rate of 6.45% affecting one of four residents observed for medication administration (Resident 56.) The medication errors were as follows: 1. Resident 56 did not receive docusate (a medication used for bowel [intestine] management) as ordered by Resident 56's physician, and 2. Resident 56 received metformin (a medication used to treat high blood sugar levels) at a different time than ordered by Resident 56's physician. These failures had the potential to result in Resident 56 to experience medication adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) and the potential to result in Residents 56's health and well-being to be negatively impacted. Findings: During an observation on 8/21/24 at 9:06 AM, in Medication Cart Station 1, Licensed Vocational Nurse (LVN) 2 was observed administering metformin 500 milligram ([mg]-a unit of measure of mass) tablet to Resident 56. Resident 56 was observed swallowing the metformin tablet whole with ensure (a nutritional drink.) LVN 2 was observed not administering docusate 100 mg tablet to Resident 56. During an interview on 8/21/24 11:07 AM, with LVN 2, LVN 2 stated that LVN 2 administered metformin 500 mg tablet and failed to prepare and administer docusate 100 mg tablet during the morning medication administration at 9:06 AM to Resident 56, as prescribed by Resident 56's physician. LVN 2 acknowledged the physician's order specified to administer metformin at 7:30 AM with meals and docusate 100 mg at 9 AM. LVN 2 stated, per facility policy, there was a 60-minute window for medication administration and LVN 2 administered the metformin later than that timeframe. LVN 2 stated that Resident 56 was at risk of having stomach irritation from not administering metformin with meals at 7:30 AM, and at risk of having constipation from not administering docusate. LVN 2 stated these were considered medication errors. LVN 2 stated that LVN 2 will notify the physician for not administering docusate to Resident 56 and obtain additional orders as necessary. During an interview on 8/23/24 10:19 AM, with the Director of Nursing (DON), the DON stated that LVN 2 failed to administer metformin 500 mg tablet and docusate 100 mg tablet according to physician orders, to Resident 56. The DON stated that Resident 56 may be at risk for developing stomach irritation from receiving metformin around 9 AM without a meal, and possibly experience constipation by not receiving docusate. The DON stated that licensed nurses should follow facility medication administration guidelines to ensure physician orders are followed and the right medications at the right times are administered to residents. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 56's Admission Record (a document containing demographic and diagnostic information,) dated 8/21/24, the Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Diabetes Mellitus 2 ([DM2] - a condition where there is high blood sugar levels) and gastritis (inflammation of the stomach lining.) During a review of Resident 56's Order Summary Report, dated 8/21/24, indicated Resident 56 was prescribed docusate 100 mg tablet twice a day for bowel management, and metformin 500 mg twice a day for diabetes to give with breakfast and dinner, starting 10/13/23. During a review of Resident 56's Medication Administration Record ([MAR] - a record of mediations administered to residents), for August 2024, the MAR indicated Resident 56 was prescribed docusate 100 mg tablet to be given orally twice a day for bowel management at 9 AM and 5 PM, and metformin 500 mg to be given twice a day orally for diabetes to give with breakfast and dinner at 7:30 AM and 5 PM. The clinical record contained no documentation that the resident should be given metformin at a time different than the one ordered by the physician, and no documentation that the resident should not be given the docusate at the time ordered by the physician. During a review of the facility's policy and procedures (P&P), titled Administering Medications, dated April 2019, the P&P indicated Medications are administered in a safe and timely manner, and as prescribed. 4. Medications are administered in accordance with prescriber orders, including any required time frame. 7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders) 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. During a review of the facility's P&P, titled Adverse consequences and Medication Errors, dated March 2023, the P&P indicated: 5. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. 6. Examples of medication error include: a. Omission - a drug is ordered but not administered; b. Wrong time c. Failure to follow manufacturer instructions and/or accepted professional standards.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555686	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Studio City Rehabilitation Center	11429 Ventura Blvd Studio City, CA 91604

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376 Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors (means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards): 1. For five of seven sampled residents (Resident 12, 38, 49, 56, 116 and 125) investigated for insulin (a hormone that lowers the level of glucose [a type of sugar] in the blood) use by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous ([SQ] -beneath the skin) insulin administration sites for 2. For one of one sampled resident (Resident 38) investigated during review of anticoagulant use by failing to rotate enoxaparin (medication to prevent and treat blood clots) subcutaneous injection sites. The deficient practice increased the risk that Residents Resident 12, 38, 49, 56, 116 and 125 could experience adverse effects (unwanted, unintended result) from same site subcutaneous administration of insulin such as lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Cross Reference F658. Findings: a. During a review of Resident 116's Admission Record, the Admission Record indicated the facility admitted the resident on 5/23/2024, with diagnoses including type 2 diabetes mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as fuel), acute kidney failure (when the body suddenly lose their ability to function), and urinary tract infection (a condition in which bacteria invade and grow in the urinary tract). During a review of Resident 116's History and Physical (H&P), dated 5/24/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 116's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/30/2024, the MDS indicated the resident rarely to never had the ability to make self-understood and understand others. The MDS indicated the resident was on a high-risk drug class hypoglycemic (medication that lowers blood sugar) (including insulin). During a review of Resident 116's Order Summary Report, dated 5/25/2024, the report indicated an order for: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- insulin regular human injection solution (Insulin Regular [Human]) Inject as per sliding scale (varies the dose of insulin based on blood sugar level): if 61-150= 0. If blood sugar (BS) less than (<) 60 may administer 8 ounces (oz., a unit of weight measurement) orange juice and call MD; 151-200= 2; 201-250= 4; 251-300= 6; 301-350= 8; 351-399= 10; 400+ If BS greater than (>) 400, administer12 units (the amount required to lower the blood sugar) and notify MD, subcutaneously every 6 hours for diabetes mellitus (DM) rotate site. During a review of Resident 116's Location of Administration of insulin for 6/2024 to 8/2024, it indicated Insulin Regular Human Injection Solution was administered on the following dates and sites: 6/11/2024 at 5:27 p.m. on the Abdomen-Left Lower Quadrant (LLQ) 6/12/2024 at 11:38 p.m. on the Abdomen-LLQ 6/19/2024 at 6:27 p.m. on the Abdomen-Right Lower Quadrant (RLQ) 6/20/2024 at 11:35 p.m. on the Abdomen-RLQ 6/20/2024 at 5:32 a.m. on the Abdomen-RLQ 6/24/2024 at 5:13 p.m. on the Abdomen-LLQ 6/25/2024 at 11:20 p.m. on the Abdomen-LLQ 7/1/2024 at 5:06 a.m. on the Abdomen-LLQ 7/2/2024 at 11:06 p.m. on the Abdomen-LLQ 7/2/2024 at 1:31 p.m. on the Abdomen-LLQ 7/10/2024 at 5:09 p.m. on the Abdomen-LLQ 7/11/2024 at 11:16 p.m. on the Abdomen-LLQ 7/22/2024 at 11:12 p.m. on the Abdomen-LLQ 7/23/2024 at 11:58 p.m. on the Abdomen-LLQ 7/25/2024 at 11:15 p.m. on the Abdomen-LLQ 7/26/2024 at 11:16 p.m. on the Abdomen-LLQ 8/8/2024 at 12:54 a.m. on the Abdomen-LLQ 8/9/2024 at 11:49 p.m. on the Abdomen-LLQ 8/12/2024 at 5:17 p.m. on the Abdomen-Right Upper Quadrant (RUQ) (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/14/2024 at 12:50 p.m. on the Abdomen-RUQ During a concurrent interview and record review on 8/22/2024, at 3:09 p.m., with Registered Nurse 4 (RN 4), reviewed Resident 116's Order Summary Report, Medication Administration Record (MAR), and Location of Administration sites of insulin for 6/2024 to 8/2024. RN 4 stated there were multiple instances where the insulin administration sites was not rotated. RN 4 stated insulin administration sites should be rotated to prevent bruising and swelling of the skin and to prevent lipodystrophy. RN 4 stated not rotating insulin administration sites constitutes as a medication error. During an interview on 8/23/2024, at 7:20 p.m., with the Director of Nursing (DON), the DON stated insulin injections sites should be rotated to prevent skin irritation and lipodystrophy. The DON stated not rotating insulin administration sites is considered a medication error. During a review of the facility's recent policy and procedure (P&P) titled, Insulin Administration, last reviewed on 4/17/2024, the P&P indicated to provide guidelines for the safe administration of insulin to residents with diabetes. Select an injection site. a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility provided Instructions for Use of Humulin ([NAME]-mu-[NAME]) R (insulin human) injection for subcutaneous or intravenous use 3 ml or 10 ml multiple-dose vial (100 units/ML), copyright 1997, indicated change (rotate) your injection sites within the area you choose for each dose to reduce your risk of getting lipodystrophy (pits in skin or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. b. During a review of Resident 38's Admission Record, the Admission Record indicated the facility admitted the resident on 4/17/2012, and readmitted the resident on 12/19/2023, with diagnoses including functional quadriplegia (a condition that causes complete immobility due to a severe physical disability or frailty, but it is not a true paralysis), type 2 diabetes mellitus, and anoxic brain damage (caused by a complete lack of oxygen to the brain, which results in the death of brain cells after approximately four minutes of oxygen deprivation). During a review of Resident 38's H&P, dated 12/19/2023, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 38's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others. The MDS indicated the resident was on high-risk drug class hypoglycemic (including insulin). During a review of Resident 38's Order Summary Report, the report indicated the following orders: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-7/2/2024 Enoxaparin Sodium Injection Solution Prefilled Syringe (anticoagulant) 40 milligrams (mg, a unit of weight)/0.4 milliliters (ml, a unit of volume) (Enoxaparin Sodium). Inject 0.4 ml subcutaneously in the morning for deep vein thrombosis (DVT, the formation of one or more blood clots) prophylaxis (ppx, measures designed to preserve health and prevent the spread of disease) rotate site (as maintenance for long term DVT PPX). -5/28/2024 Novolog Injection Solution (Insulin Aspart). Inject as per sliding scale: if 70-140= 0 <70 may give 8 oz orange juice and notify MD; 141-220= 1 unit; 221-260= 2 units; 261-280= 3 units; 281-300= 4 units; 301-350= 5 units; 351+= 6 units >350 give 6 units and notify MD, subcutaneously every 12 hours for DM rotate site. During a review of Resident 38's Care Plan (CP) titled, Anticoagulant, (a substance that is used to prevent and treat blood clots), and At risk for bleeding and bruises due to anticoagulant therapy, last revised on 12/20/2023, the CP indicated an intervention to administer medication as ordered. During a review of Resident 38's Location of Administration of Enoxaparin Sodium Injection Solution Prefilled Syringe 40 mg/0.4 ml for 5/2024 to 8/2024, it indicated the following dates and sites of administration: 5/5/2024 at 9:25 a.m. on the Abdomen-LUQ 5/6/2024 at 9:23 a.m. on the Abdomen-LUQ 5/9/2024 at 9:02 a.m. on the Abdomen-LUQ 5/10/2024 at 8:49 a.m. on the Abdomen-LUQ 5/11/2024 at 9:12 a.m. on the Abdomen-LUQ 6/11/2024 at 9:02 a.m. on the Abdomen-LUQ 6/12/2024 at 9:09 a.m. on the Abdomen-LUQ 8/8/2024 at 8:43 a.m. on the Abdomen-RLQ 8/9/2024 at 9:31 a.m. on the Abdomen-RLQ 8/17/2024 at 9:33 a.m. on the Abdomen-RUQ 8/18/2024 at 9:13 a.m. on the Abdomen-RUQ During a review of Resident 38's Location of Administration of Novolog Injection Solution for 6/2024 to 8/2024, it indicated the following dates and sites of administration: 6/9/2024 at 5:11 p.m. on the Abdomen-LLQ 6/20/2024 at 5:37 a.m. on the Abdomen-LLQ (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/21/2024 at 5:27 a.m. on the Abdomen-LLQ 7/8/2024 at 5:20 p.m. on the Abdomen-RLQ 7/9/2024 at 5:13 a.m. on the Abdomen-RLQ 7/14/2024 at 5:13 a.m. on the Abdomen-LLQ 7/16/2024 at 5:18 a.m. on the Abdomen-LLQ 7/17/2024 at 5:03 a.m. on the Abdomen-RLQ 7/18/2024 at 5:06 a.m. on the Abdomen-RLQ 7/23/2024 at 5:12 a.m. on the Abdomen-RLQ 7/24/2024 at 5:31 a.m. on the Abdomen-RLQ During a concurrent interview and record review on 8/22/2024, at 3:15 p.m., with RN 4, reviewed Resident 38's Order Summary Report, MAR, and Location of Administration sites of insulin from 6/2024 to 8/2024 and Enoxaparin Sodium Injection from 5/2024 to 8/2024. RN 4 stated there were multiple instances where the insulin and enoxaparin administration sites were not rotated. RN 4 stated the insulin and enoxaparin administration sites should be rotated to prevent bruising and swelling of the skin and to prevent lipodystrophy. RN 4 stated not rotating insulin and enoxaparin administration sites constitutes as a medication error. During an interview on 8/23/2024, at 7:20 p.m., with the DON, the DON stated insulin and enoxaparin injection sites should be rotated to prevent skin irritation and lipodystrophy. The DON stated not rotating insulin and enoxaparin administration sites is considered a medication error. During a review of the facility's recent policy (P&P) and procedure titled, Adverse Consequences and Medication Errors, last reviewed on 4/17/2024, the P&P indicated a medication error is defined as the preparation of drugs and biological which is not in accordance with physician's orders, manufacturers specifications, or accepted professional standards and principles of the professional(s) providing services. During a review of the facility's recent policy and procedure (P&P) titled, Insulin Administration, last reviewed on 4/17/2024, the P&P indicated to provide guidelines for the safe administration of insulin to residents with diabetes. Select an injection site. a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility provided instructions for use of Enoxaparin Sodium Injection for subcutaneous use single-dose prefilled syringe, undated, it indicated to alternate between the left or the right side of the stomach each time an injection is given. During a review of the facility provided Instructions for Use of Humulin ([NAME]-mu-[NAME]) R (insulin human) injection for subcutaneous or intravenous use 3 ml or 10 ml multiple-dose vial (100 units/ML), copyright 1997, it indicated change (rotate) your injection sites within the area you choose for each dose to reduce your risk of getting lipodystrophy (pits in skin or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. During a review of the facility provided Highlights of Prescribing Information for Insulin Aspart injection, for subcutaneous or intravenous use, with initial U.S. approval in 2000, indicated to rotate the injection sites within the same region from one injection to the next to reduce the risk of lipodystrophy and localized cutaneous amyloidosis. c. During a review of Resident 125's Admission Record, the Admission Record indicated the facility admitted the resident on 2/26/2022, and readmitted the resident on 3/1/2024, with a diagnosis of type 2 diabetes mellitus. During a review of Resident 125's H&P, dated 3/1/2024, the H&P indicated the incapacitated resident requires visit for safety. During a review of Resident 125's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and sometimes understands others. The MDS indicated the resident was on a high-risk drug class hypoglycemic (including insulin). During a review of Resident 125's Order Summary Report, dated 4/2/2024, the report indicated an order for Insulin Aspart FlexPen Solution Pen-injector 100 unit/ml (Insulin Aspart). Inject as per sliding scale: if 60-150= 0 units; 151-199= 2 units; 200-249= 3 units; 250-299= 5 units; 300-349= 7 units; 350-400= 10 units; subcutaneously every 12 hours for diabetes type 2 (DM II) (rotate injection sites) finger-stick blood sugar (FSBS, a method of monitoring blood sugar) monitoring. Notify MD if BS < 70 mg/dl or >400 mg/dl. May give 8 oz orange juice if BS < 70 mg/dl and notify MD. During a review of Resident 125's Location of Administration of Insulin Aspart FlexPen Solution Pen-injector 100 unit/ml from 6/2024 to 8/2024, it indicated the following administration dates and sites: 6/4/2024 at 5:15 a.m. on the Abdomen-LLQ 6/7/2024 at 5:06 a.m. on the Abdomen-LLQ 6/10/2024 at 5:38 a.m. on the Abdomen-LLQ 6/11/2024 at 5:26 a.m. on the Abdomen-LLQ 6/12/2024 at 5:05 a.m. on the Abdomen-LLQ 6/13/2024 at 5:33 a.m. on the Abdomen-LLQ (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/17/2024 at 5:36 a.m. on the Abdomen-LLQ 6/19/2024 at 5:14 a.m. on the Abdomen-LLQ 6/20/2024 at 5:31 a.m. on the Abdomen-LLQ 6/21/2024 at 5:19 a.m. on the Abdomen-LLQ 6/24/2024 at 5:19 a.m. on the Abdomen-RLQ 6/26/2024 at 5:15 a.m. on the Abdomen-RLQ 6/27/2024 at 5:24 a.m. on the Abdomen-RLQ 7/8/2024 at 5:12 a.m. on the Abdomen-RLQ 7/9/2024 at 5:15 a.m. on the Abdomen-RLQ 7/10/2024 at 5:11 a.m. on the Abdomen-RLQ 7/11/2024 at 5:09 a.m. on the Abdomen-RLQ 7/12/2024 at 5:07 a.m. on the Abdomen-RLQ 7/15/2024 at 5:16 a.m. on the Abdomen-RLQ 7/17/2024 at 5:07 a.m. on the Abdomen-RLQ 7/18/2024 at 5:08 a.m. on the Abdomen-RLQ 7/21/2024 at 5:30 a.m. on the Abdomen-RLQ 7/22/2024 at 5:10 a.m. on the Abdomen-RLQ 7/23/2024 at 5:16 a.m. on the Abdomen-RLQ 7/24/2024 at 5:33 a.m. on the Abdomen-RLQ 7/25/2024 at 5:20 a.m. on the Abdomen-RLQ 8/1/2024 at 5:07 a.m. on the Abdomen-RLQ 8/2/2024 at 5:03 a.m. on the Abdomen-RLQ During a review of Resident 125's Care Plan (CP) titled, Resident at risk for hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) related to diabetes mellitus, last revised on 3/9/2022, the CP indicated an intervention to administer medications as ordered. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/22/2024, at 3:19 p.m., with RN 4, reviewed Resident 125's Order Summary Report, MAR, and Location of Administration sites of insulin from 6/2024 to 8/2024. RN 4 stated there were multiple instances where the insulin administration sites were not rotated. RN 4 stated insulin administration should be rotated to prevent bruising and swelling of the site and to prevent lipodystrophy. RN 4 stated not rotating insulin administration sites constitutes as a medication error. During an interview on 8/23/2024, at 7:20 p.m., with the DON, the DON stated insulin and enoxaparin injections sites should be rotated to prevent skin irritation and lipodystrophy. The DON stated not rotating insulin and enoxaparin administration sites is considered a medication error. During a review of the facility's recent policy (P&P) and procedure titled, Adverse Consequences and Medication Errors, last reviewed on 4/17/2024, the P&P indicated a medication error is defined as the preparation of drugs and biological which is not in accordance with physician's orders, manufacturers specifications, or accepted professional standards and principles of the professional(s) providing services. During a review of the facility's recent policy and procedure (P&P) titled, Insulin Administration, last reviewed on 4/17/2024, the P&P indicated to provide guidelines for the safe administration of insulin to residents with diabetes. Select an injection site. a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility provided instructions for use of Enoxaparin Sodium Injection for subcutaneous use single-dose prefilled syringe, undated, it indicated to alternate between the left or the right side of the stomach each time an injection is given. During a review of the facility provided Instructions for Use of Humulin ([NAME]-mu-[NAME]) R (insulin human) injection for subcutaneous or intravenous use 3 ml or 10 ml multiple-dose vial (100 units/ML), copyright 1997, it indicated change (rotate) your injection sites within the area you choose for each dose to reduce your risk of getting lipodystrophy (pits in skin or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. During a review of the facility provided Highlights of Prescribing Information for Insulin Aspart injection, for subcutaneous or intravenous use, with initial U.S. approval in 2000, indicated to rotate the injection sites within the same region from one injection to the next to reduce the risk of lipodystrophy and localized cutaneous amyloidosis. 43455 d.1. During a review of Resident 12's Admission Record (a document containing demographic and diagnostic information,) dated 8/22/24, it indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Type 2 Diabetes Mellitus 2 ([DM2] - a condition where there is high blood sugar levels.) (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 12's Order Summary Report, dated 8/22/24, it indicated Resident 12 was prescribed Lantus (long-acting insulin) to inject 20 units ([un] - a measure of dosage for insulin) SQ at bedtime for DM rotate sites, starting 2/21/24. During a review of Resident 12's Medication Administration Record ([MAR] - a record of mediations administered to residents), for August 2024, the MAR indicated Resident 12 was prescribed Lantus 20 un SQ to give at bedtime for DM rotate sites, at 9 PM. During the same review, the MAR indicated Lantus 20 units SQ was administered at bedtime on the following days and sites: 8/13/24 at 9 PM on Right Upper Quadrant ([RUQ] - upper right side of abdomen) 8/14/24 at 9 PM on RUQ During a review of Resident 56's Admission Record dated 8/21/24, it indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including DM2. d.2. During a review of Resident 56's Order Summary Report, dated 8/21/24, it indicated Resident 56 was prescribed Novolog (fast-acting insulin) to inject per sliding scale (insulin dosing plan whereby the amount of insulin administered depends on the resident's blood sugar level,) SQ before meals for DM2 (rotate site,) starting 10/13/23. During a review of Resident 56's MAR for June and July 2024, the MAR indicated Resident 56 was prescribed Novolog to inject per sliding scale SQ before meals for DM2 (rotate site,) at 6:30 AM, 11:30 AM and 4:30 PM. During the same review, the MAR indicated Novolog SQ was administered on the following days, times and sites: 6/27/24 at 6:30 AM on Left Lower Quadrant ([LLQ] - lower left side of abdomen) 6/27/24 at 4:30 PM on LLQ 6/28/24 at 6:30 AM on Right Lower Quadrant ([RLQ] - right left side of abdomen) 6/27/24 at 4:30 PM on RLQ 6/30/24 at 11:30 AM on RLQ 6/30/24 at 4:30 PM on RLQ 7/10/24 at 4:30 PM on LLQ 7/11/24 at 4:30 PM on LLQ 7/23/24 at 4:30 PM on LLQ (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/24/24 at 4:30 PM on LLQ During a concurrent interview and record review on 8/23/24 at 8:57 AM, with Registered Nurse (RN) 7, RN 7 reviewed Resident 12's and 56's MAR for August 2024 and for June and July 2024, respectively. RN 7 stated that Resident 12 MAR indicated to rotate injection sites for Lantus and Resident 56 MARs indicated to rotate injection site for Novolog. RN 7 stated that for Resident 12 and 56 the MARs indicated there were multiple instances where the insulin administration sites were not rotated by several licensed nurses, as expected by standard of practice, manufacturer guidelines, and MAR order instructions. RN 7 stated the failure of the licensed nurses to rotate insulin administration sites could cause harm to Resident 12 and 56 by causing skin abnormalities such as lumps in the skin or thickened skin. RN 7 stated not rotating insulin administration sites was considered a medication error. During an interview on 8/23/24, at 10:19 AM, with the Director of Nursing (DON,) the DON stated that per facility policy and manufacturer guidelines it was common knowledge for licensed nurses to rotate insulin administration sites to prevent lipodystrophy to the sites that was frequently administered with insulin. The DON stated that several licensed nurses failed to rotate the insulin administration sites for Resident 12 and 56 and placed the residents at risk of harm from lipodystrophy. The DON stated not rotating insulin administration sites was considered a medication error. Review of the facility's P&P, titled Adverse consequences and Medication Errors, dated March 2023, the P&P indicated: 2. An 'adverse consequence' is defined as an unpleasant symptoms or event that is due to or associated with a medication, such as an impairment or decline in an individual's mental or physical condition or functional or psychosocial status. An adverse consequence may include: a.adverse drug/medication reaction 3. The staff and practitioner shall strive to minimize adverse consequences by: a.Following relevant clinical guidelines and manufacturer's specifications for use, dose, administration, duration, and monitoring of the medication; 5. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. 5 .Examples of medication error include: h.Failure to follow manufacturer instructions and/or accepted professional standards. During a review of facility's P&P titled, Insulin Administration, dated September 2014, the P&P indicated: To provide guidelines for the safe administration of insulin to residents with diabetes. 3. The type of insulin, .and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	16.b. injection sites should be rotated, preferably within the same general area. During a review of manufacturer's guide for Injecting Lantus with a vial and syringe, dated 2022, the guide indicated to Change (rotate) your injection sites within the area you chose with each dose to reduce your risk of getting lipodystrophy (pitted or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. Do not use the same spot for each injection or inject where the skin is pitted, thickened, lumpy, tender, bruised, scaly, hard, scarred or damaged. During a review of manufacturer's guide for Instructions for use for Novolog, dated 1/2015, the guide indicated Injection sites should be rotated within the same region to reduce the risk of lipodystrophy. For each injection, change (rotate) your injection site within the area of skin that you use. Do not use the same injection site for each injection. 43988 e. During a review of Resident 49's Admission Record, the Admission Record indicated the facility admitted the resident on 8/4/2021 and readmitted in the facility on 5/8/2024 with diagnoses including but not limited to heart failure (a long-term condition that happens when the heart cannot pump blood well enough to give the body a normal supply), type two diabetes mellitus (DM 2 - a long term condition that causes the level of sugar [glucose] in the blood to become too high), and dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). During a review of Resident 49's History and Physical (H&P) dated 5/10/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 49's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 8/13/2024, the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and require total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 49 received insulin. During a review of Resident 49's Order Summary Report, the report indicated the following physician's order dated 5/8/2024: o Basaglar KwikPen (insulin glargine - a long-acting insulin used to control high blood sugar) subcutaneous solution pen-injector 100 unit per milliliter (unit/ml - a unit of measurement) inject 20 units subcutaneously in the morning for DM rotate sites. o Basaglar KwikPen (insulin glargine - a long-acting insulin used to control high blood sugar) subcutaneous solution pen-injector 100 unit per milliliter (unit/ml - a unit of measurement) inject 20 units subcutaneously at bedtime for DM rotate sites. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o Humalog KwikPen (insulin lispro - a quick acting insulin used to improve blood sugar control in people with DM) subcutaneous solution Pen-injector 100 unit/ml (insulin lispro) inject subcutaneously per sliding scale: if 60 - 130 = 0; 131 - 160 = 2; 161 - 200 = 3; 201 - 250 = 4; 251 - 300 = 6; 301 - 350 = 8; 351 - 400 = 10 more than 400= 10 units and call physician ,before meals and at bedtime for DM [ROTATE SITE] notify physician if blood sugar is above 400 milligram per deciliter (mg/dl - a unit of measurement or below 60mg/dl, may give five 8 ounces (oz - a unit of measurement) orange juice by mouth if blood sugar is below 60mg/dl. o Fiasp injection solution (insulin aspart with niacinamide - a rapid acting insulin indicated to improve glycemic control in patients with DM) 100 unit /ml inject seven (7) unit subcutaneously before meals for DM 2 (ROTATE SITES) notify physician if blood sugar is above 400 mg/dl or below 60mg/dl, may give 8oz orange juice by mouth if blood sugar is below 60mg/dl. Hold for blood sugar less than 100 administer 10-15 minutes prior to eating meals or as close as possible to mealtime. During a review of Resident 49's Medication Administration Record (MAR) from 6/2024 to 8/2024, the MAR indicated Basaglar insulin injection solution was administered as follows: 6/7/2024 9:00 a.m. subcutaneously Abdomen Right lower Quadrant (RLQ) 6/7/2024 9:00 p.m. subcutaneously Abdomen RLQ 6/8/2024 9:00 a.m. subcutaneously Abdomen Right Upper Quadrant (RUQ) 6/8/2024 9:00 p.m. subcutaneously Abdomen RUQ 6/13/2024 9:00 a.m. subcutaneously Right Arm (RA) 6/13/2024 9:00 p.m. subcutaneously RA 6/14/2024 9:00 a.m. subcutaneously Abdomen RUQ 6/14/2024 9:00 p.m. subcutaneously Abdomen RUQ 6/22/2024 9:00 a.m. subcutaneously Abdomen RLQ 6/22/2024 9:00 p.m. subcutaneously Abdomen RLQ 7/1/2024 9:00 a.m. subcutaneously Abdomen RUQ 7/1/2024 9:00 p.m. subcutaneously Abdomen RUQ 7/12/2024 9:00 a.m. subcutaneously Abdomen Left Upper Quadrant (LUQ) 7/12/2024 9:00 p.m. subcutaneously Abdomen LUQ 7/15/2024 9:00 a.m. subcutaneously Abdomen Left Lower Quadrant (LLQ) 7/15/2024 9:00 p.m. subcutaneously Abdomen LLQ (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/17/2024 9:00 a.m. subcutaneously Abdomen Left Lower Quadrant (LLQ) 7/17/2024 9:00 p.m. subcutaneously Abdomen LLQ 7/19/2024 9:00 a.m. subcutaneously Abdomen RLQ 7/19/2024 9:00 p.m. subcutaneously Abdomen RLQ 7/23/2024 9:00 a.m. subcutaneously Abdomen RLQ 7/23/2024 9:00 p.m. subcutaneously Abdomen RLQ 7/25/2024 9:00 a.m. subcutaneously Abdomen LUQ 7/25/2024 9:00 p.m. subcutaneously Abdomen LUQ 7/31/2024 9:00 a.m. subcutaneously Abdomen RLQ 7/31/2024 9:00 p.m. subcutaneously Abdomen RLQ During a review of Resident 49's Medication Administration Record (MAR) from 6/2024 to 8/2024, the MAR indicated Humalog insulin injection solution was administered as follows: 06/20/2024 9:00 p.m. subcutaneously Abdomen - Left Lower Quadrant (LLQ) 06/21/2024 11:30 subcutaneously Abdomen - LLQ 06/23/2024 11:30 subcutaneously Abdomen - LLQ 06/23/2024 21:00 subcutaneously Abdomen - LLQ 07/04/24 21:00 subcutaneously Abdomen - LUQ 07/06/24 11:30 subcutaneously Abdomen - LUQ 07/16/24 21:00 subcutaneously Abdomen - Left Lower Quadrant (LLQ) 07/17/24 11:30 subcutaneously Abdomen - LLQ 08/01/24 11:30 subcutaneously Abdomen - LLQ 08/01/24 16:30 subcutaneously Abdomen - LLQ 08/19/24 11:30 subcutaneously Abdomen - LLQ 08/19/24 16:30 subcutaneously Abdomen - LLQ (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 49's Medication Administration Record (MAR) from 6/2024 to 8/2024, the MAR indicated Fiasp insulin injection solution was administered as follows: 06/08/24 16:30 subcutaneously Abdomen - LUQ 06/09/24 11:30 subcutaneously Abdomen - LUQ 08/08/24 11:30 subcutaneously Abdomen - LUQ 08/08/24 16:30 subcutaneously Abdomen - LUQ 08/10/24 16:30 subcutaneously Abdomen - LUQ 08/11/24 06:30 subcutaneously Abdomen - LUQ 08/19/24 11:30 subcutaneously Abdomen - LLQ 08/19/24 16:30 subcutaneously Abdomen - LLQ During a concurrent interview and record review on 8/23/2024 at 3:30 p.m., with Minimum Data Set Coordinator 2 (MDSC 2), reviewed Resident 49's physician's orders, MAR, and location of administration sites from 6/2024 to 8/2024. MDSC 2 verified the physician's order that indicated to rotate insulin administration sites. MDSC 2 stated there were multiple repeated insulin administration on the same sites between 6/2024 to 8/2024. During an interview on 8/23/2024 at 7:10 p.m., the Director of Nursing (DON), the DON stated the licensed nurses should rotate the insulin administration site to prevent residents from developing lipodystrophy. The DON stated if the licensed nurses do not rotate the insulin administration it is considered a medication error due to not following physician's order and the manufacturer's guideline. During a review of the facility's policy and procedure titled, Adverse Consequences and Medication Errors, last reviewed on 4/17/2024, indicated: 1. The staff and practitioner shall strive to minimize adverse consequences by following relevant clinical guidelines and manufacturer's specifications for use, dose, administration, duration, and monitoring of the medication. 2. A medication error is defined as the preparation of drugs and biological which is not in accordance with physician's orders, manufacturers specifications, or accepted professional standards and principles of the professional(s) providing services. 3. Example of medication errors include failure to follow manufacturer instructions

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 43455 Based on observation, interview, and record review the facility failed to: 1. Remove and discard from use one open lorazepam (a controlled substance [CS]- medications which have potential for abuse and may also lead to physical or psychological dependence that is used for anxiety and agitation) vial for Resident 28, in accordance with manufacturer's requirements and facility policy and procedures, in two of two inspected medication rooms (Medication Room Station 3.) 2. Remove and discard from use one open, expired lorazepam vial for Resident 78 and one open Aplisol (medication used to diagnose tuberculosis [infection in the lungs]) vial for facility stock, in accordance with manufacturer's requirements and facility policy and procedures in two of two inspected medication rooms (Medication Room Station 1.) These deficient practices increased the risk that Resident 28, 78 and other residents in the facility to receive medication that had become ineffective or toxic due to improper storage or labeling, possibly leading to health complications resulting in hospitalization . Findings: During an observation, on 8/20/24 at 2:06 PM, with Licensed Vocational Nurse (LVN) 3, in Medication Room Station 1, the following medication was found expired and not discarded, or stored contrary to facility policies: 1. One open lorazepam multi-dose (containing more than one dose) vial for Resident 78 was found stored in the refrigerator and labeled with a date indicating that use of the vial began on 7/6/24. According to the manufacturer's product storage and labeling, open lorazepam multi-dose vials should be stored in a refrigerator between 36 and 46 degrees Fahrenheit and used or discarded from use within 28 days of opening the vial. During a concurrent interview with LVN 3, LVN 3 stated the lorazepam vial for Resident 78 was open and labeled with a date indicating that use of the vial began on 7/6/24. LVN 3 stated lorazepam multi-use vials are good for 28 days from when first used and that the vial was expired. LVN 3 stated that expired lorazepam has decreased potency (effectiveness) and sterility (free from germs like bacteria and virus.) LVN 3 stated the vial should be removed from the refrigerator to prevent accidental use. LVN 3 stated using expired lorazepam could potentially lead to infections, be ineffective and not treat or control Resident 78's seizures possibly leading to hospitalization and death. During an observation, on 8/20/24 at 3:16 PM, with LVN 9, in Medication Room Station 3, the following medication was found either stored and not labeled with an open date as required by their respective manufacturer's specifications, expired and not discarded, or stored contrary to facility policies: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. One open lorazepam multi-dose vial for Resident 28 was found stored in the refrigerator without a label indicating when use began. According to the manufacturer's product storage and labeling, open lorazepam multi-dose vials should be stored in a refrigerator between 36 and 46 degrees Fahrenheit and used or discarded from use within 28 days of opening the vial. During a concurrent interview with LVN 9, LVN 9 stated the lorazepam vial for Resident 28 was open and not labeled with the date when use of the vial began. LVN 9 stated lorazepam multi-use vials are good for 28 days from when first used and without knowing when use began the vial was considered expired and should not be used due to unknown expiration date. LVN 9 stated the expired vial should be removed from the refrigerator to prevent accidental use. LVN 9 stated expired lorazepam has decreased sterility and potency and when used in error could potentially lead to infections, be ineffective by not treating or controlling Resident 28's seizures possibly leading to hospitalization and death. During an observation, on 8/21/24 at 12:06 PM, with Registered Nurse (RN) 5, in Medication Room Station 1, the following medication was found either stored and not labeled with an open date as required by their respective manufacturer's specifications, expired and not discarded, or stored contrary to facility policies: 3. One open Aplisol multi-dose vial for facility stock was found stored in the refrigerator without a label indicating when storage or use began. During a review of the manufacturer's product storage and labeling, it indicated Aplisol vials should be stored in the refrigerator between 36 and 46 degrees Fahrenheit and used or discarded from use within 30 days of opening the vial. During a concurrent interview, RN 5 stated that the Aplisol vial in the refrigerator in Medication Room Station 1 was open and did not have a label indicating when the vial was opened. RN 5 stated without a label indicating when the vial was opened it would be unknown when the Aplisol would expire. RN 5 stated the vial was considered expired and should be removed from the refrigerator and placed in the expired medication bin to be disposed of and not accidentally used for residents. RN 5 stated administering expired Aplisol to residents may result in inaccurate results (either false negative or false positive) and therefore lead to providing the incorrect treatment to the residents. During an interview, on 8/23/24 at 10:19 AM, with the Director of Nursing (DON,) the DON stated the Aplisol vial for facility stock was not labeled with a date indicating when use began. The DON stated multi-dose products should be labeled with a date open to know when they expire and not to be used beyond that date as the sterility and potency of the medication will be affected. The DON stated using Aplisol vials beyond the expiration date in error may potentially provide inaccurate results leading to inaccurate treatment for residents. The DON stated the Aplisol vial was considered expired and needed to be removed from the medication room and be discarded to prevent accidental use. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the same interview, the DON stated the lorazepam vials for Resident 28 and 78, was stored in the medication room refrigerators and not labeled with a date indicating when use began and expired, respectively. The DON stated multi-dose vials should be used within 28 days of opening the vial. The DON stated expired lorazepam vials have decreased potency and sterility and when used may potentially cause infections and be ineffective in treating causing Resident 28's and 78's seizures. The DON stated both vials were considered expired and needed to be disposed of to prevent accidental use. The DON stated several LVN's failed to label and remove expired medications from the refrigerators which can potentially lead to the accidental use of expired medications and harm residents. Duirng a review of facility's Policy and Procedures (P&P) titled, Storage of Medications, dated April 2008, indicated that Medications and biologicals ae stored safely, and properly, following manufacturer's recommendations or those of the supplier. M. Outdated, contaminated, or deteriorated medications .are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. During a of the facility's P&P, titled Administering Medications, dated April 2019, the P&P indicated Medications are administered in a safe and timely manner, and as prescribed. 12. The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container. During a review of facility's P&P titled, Vials and Ampules of Injectable Medications, dated April 2008, the P&P indicated that Vials and ampules of injectable medications are used in accordance with the manufacturer's recommendations or the provider pharmacy's directions for storage, use, and disposal. B. The date opened and the initials of the first person to use the vial are recorded on the multi-dose vials (on the vial label or an accessory label affixed for that purpose). F. Medications in multi-dose vials may be used until manufacturer's expiration date or 6 months after opening unless otherwise specified. Refer to Guide for Special Handling of Medications. During a review of facility's P&P, titled Guide for Special Handling of Medications, dated September 2023, the P&P listed the following: Multi-Dose Vials for Injection - date when opened and discard unused portions after 28 days or in accordance with manufacturer's recommendations. Aplisol Injection - Store in the refrigerator. Protect from light. Do not freeze. Date when opened and discard unused portion after 30 days.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 43418 Based on observation, interview, and record review, the facility failed to prepare food by methods that conserved flavor, appearance, and temperature when a. one of three sampled residents (Resident 128) investigated under the food care area when Resident 128 was served food that did not appear attractive to the resident on 8/20/2024. b. Italian herb vegetables were mushy and overcooked. Red and green salad and peach crisp looked saggy (wet and soft). c. Red and green salad was at 54 degrees Fahrenheit ([F] a scale of temperature). These deficient practices resulted in Resident 128 not eating their meal and placed 20 of 44 facility residents on regular consistency texture (texture with no restriction) at risk of unplanned weight loss, a consequence of poor food intake, getting food from the kitchen. Findings: a. During a review of Resident 128's Admission Record, the admission record indicated the facility admitted Resident 128 on 7/30/2022 with diagnoses including, but not limited to, unspecified protein-calorie malnutrition (nutritional status in which reduced availability of nutrients leads to changes in body composition and function) and generalized weakness. During a review of Resident 128's Minimum Data Set (a standardized assessment and care screening tool), dated 7/22/2024, the MDS indicated Resident 128 was able to understand and make decisions, requires setup or clean-up assistance with eating, and requires touching assistance to moderate assistance for activities of daily living such as hygiene, dressing, toileting, and mobility. During a review of Resident 128's Order Summary Report, dated 7/16/2024, indicated Resident 128 was ordered a no added salt diet, with a mechanical soft texture (a texture-modified diet that makes foods easier to chew and swallow by reducing the size and softening them). During a review of Resident 128's Task titled, Nutritional - Amount Eaten, dated 8/20/2024, indicated Resident 128 ate 40 percent of their first meal, zero percent of their second meal, and refused his third meal. During an interview with Resident 128, on 8/20/2024, at 9:40 a.m., Resident 128 stated the food he is served in the facility is bland (lacking taste or seasoning) and does not look appetizing. During a concurrent observation and interview with Resident 128, on 8/20/2024, at 1:06 p.m., inside Resident 128's room, Resident 128's bedside table had a meal tray containing a plate with a bread roll, whole broccoli, a scoop sized portion of brown colored shredded meat, and a scoop sized portion of brown colored moist and mashed breading. Resident 128 stated the food he was served did not look appetizing to him. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	47441 b/c. A review of the facility's summer menu spreadsheets (a list containing types and amount of foods of what each diet type would receive) dated 8/21/2024, indicated regular texture diet included the following food items on the tray: Fish Italiano 3 ounces (oz, unit of measurement) Tartar sauce 1 tablespoon (Tbsp, household measurement. Scalloped potatoes 1/2 cup (c) Italian Herb Vegetables 1/2 c Red and green salad 1/2 c Dressing 1/2 oz Peach crisp (3x2 1/2 inches [in.]) Milk 4 oz During a trayline (an area where food was assembled) observation on 8/21/2024 at 11:33 a.m., staff started placing cold salad on the trays in the cart. There was a pan of Italian herb vegetables in the oven covered with foil. During a trayline observation on 8/21/2024 at 12:36 p.m. a pan of vegetables from the oven was placed on the team table looked mushy and served to regular diet textures. During the end of trayline service observation on 8/21/2024 at 12:58 p.m. 20 resident's trays on regular diet texture was served mushy vegetables. During a test tray conducted with the Dietary Director (DD), Registered Dietitian (RD) and [NAME] 1 on 8/21/2024 at 12:59 p.m. for regular diet (diet with no restrictions), the Italian herb vegetables was mushy, and overcook. The peach crisp looked soggy and the red and green salad looked wilted. Red and green salad was at 54 F. DD stated the cold items particularly the red and green vegetables could be dish out better as it looked like the staff just dumped it. DD stated it looked soggy and the peach crisp was not crispy. DD stated the peach crisp was recommended to be served hot or room temperature. DD stated the Italian herb vegetables were overcooked. [NAME] 1 stated she placed the cooked vegetables inside the oven while waiting for it to be served. DD stated it is important not to overcook vegetables as it loses its nutrients. RD stated it was important to have a presentable food as it could stimulate appetite of the residents to prevent weight loss. During an interview with the Director of Nursing (DON), on 8/23/2024, at 7:10 p.m., the DON stated it is important that residents are served food that is palatable because it can affect residents' appetites which can lead to potential weight loss and weakness. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's diet manual titled Regular diet dated 4/17/2024, indicated DESCRIPTION: The regular diet is designed to meet the nutritional needs of resident who do not need dietary modification or restriction. Individual preferences or intolerances may necessitate the exclusion of certain food items. During a review of the facility's recipe titled Recipe: Italian Herb Vegetables dated week 4, Wednesday, 2024, it indicated Temperature: steam or simmer. During a review of the facility's recipe titled Recipe: Red and [NAME] Salad undated, it indicated Serve on trayline at a recommended temperature of 41 F or less. During a review of the facility's policies and procedures (P&P) titled Food Preparation dated 4/17/2024, it indicated POLICY. Food is to be prepared in such a manner as to maximize flavor, appearance, and nutritional value. Procedure: (1) All food will be prepared by methods that preserve nutritive value, flavor, and appearance and will be attractively served at the proper temperature and in a form to meet the individual needs of the resident. (2) All recipes in use shall be standardized and will be maintained in a file or book accessible to the dietary staff. Recipes used are consistent to what is on the menu. (6) Prepare foods as close as possible to serving time in order to preserve the nutritive value, freshness, and to prevent overcooking.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44244 Based on observation, interview and record review, the facility failed to accommodate food preferences and provide appealing options of similar nutritive value to residents who choose not to eat food that is initially served for two of sixteen sampled residents (Resident 122 and 84) reviewed during the Dining task by failing to: a. Ensure Resident 122 was offered a food substitute after verbalizing that they did not like the meat provided with lunch. b. Ensure Resident 84 did not receive pasta with lunch when Resident 84 had a dislike of pasta. This deficient practice had the potential to result in further weight loss in Resident 122 and not respect Resident 84's wishes. Findings: a. During a review of Resident 122's Admission Record, the Admission Record indicated the facility admitted the resident on 10/4/2022 with diagnoses that included metabolic encephalopathy (an alteration in consciousness due to brain dysfunction), moderate protein-calorie malnutrition (an energy deficit due to a lack of dietary protein [a nutrient needed for the body to function properly]), and unspecified dementia (general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). During a review of Resident 122's Minimum Data Set (MDS - an assessment and care screening tool) dated 7/19/2024, the MDS indicated the resident was able to understand others and was able to make herself understood. The MDS indicated the resident required setup or clean-up assistance with eating. The MDS further indicated the resident had a weight loss of five percent (a unit of measurement) or more in the last month or loss of ten percent or more in the last six months. During a review of Resident 122's History and Physical (H&P) dated 7/12/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 122's Care Plan (CP) titled, Alteration in nutritional status secondary to poor oral intake . initiated 10/5/2022 and revised on 5/1/2024, the CP indicated to offer food substitutes if resident refuses meal tray or has poor intake. During a concurrent observation and interview on 8/20/2024 at 12:32 p.m., Resident 122 sat in a wheelchair in the Rec Dining Room and was observed self-feeding. Observed the resident did not eat the meat on the plate. Resident 122 stated she did not like the meat. Resident 122 stated this facility does not offer food substitutes. During an observation on 8/20/2024 at 12:40 p.m., observed Resident 122 stated to Licensed Vocational Nurse 10 (LVN 10) that she did not like the meat on the tray. Observed LVN 10 repeated to the resident you do not like the meat. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 8/20/2024 at 12:45 p.m., observed Resident 122 self-propelled in her wheelchair toward the door. Observed Treatment Nurse 1 (TN 1) asked the resident if she did not like the meat. Resident 122 replied she did not like the meat. Observed TN 1 placed Resident 122's dirty tray in the meal cart. TN 1 stated Resident 122 did not eat the meat served at lunch. Observed the meat remained on Resident 122's plate. During an interview on 8/20/2024 at 1:55 p.m., Resident 122 sat on her bed and stated she was never offered an alternative to the meat provided at lunch. Resident 122 again stated alternatives are not offered in this facility. Resident 122 stated she was still a little hungry. During an interview on 8/20/2024 at 2:15 p.m., TN 1 stated she did not offer an alternative food choice to Resident 122 when the resident stated she did not like the meat, but she should have. TN 1 stated the facility provides an alternative menu and she should have offered it to Resident 122 for the resident's nutrition and because she may still be hungry. During an interview on 8/20/2024 at 2:20 p.m., LVN 10 stated she did not offer Resident 122 an alternative food choice at lunch because the resident stated that she was going to eat the meat even though she didn't like it. During an interview on 8/23/2024 at 12:11 p.m., the Assistant Director of Nursing (ADON) stated alternative food choices should be offered when a resident verbalizes that they don't like the food provided. The ADON stated it was a team effort and TN 1 and LVN 10 should have offered Resident 122 an alternative even if the resident stated she would eat the meat. The ADON stated it was important to offer alternatives to meet the nutritional needs of the resident and meat is an important protein needed for resident strength and muscle mass. During a review of the facility policy and procedure titled, Weight Assessment and Intervention, last reviewed 4/17/2024, the policy indicated resident weights are monitored for undesirable or unintended weight loss. Interventions for undesirable weight loss are based on careful consideration of resident choices and preferences. During a review of the Licensed Vocational Nurse Job Description, approval date 3/7/2024, indicated the LVN's essential job duties and responsibilities include to make sure residents are provided with good nutrition. 41379 b. During a concurrent observation and interview on 8/20/24 at 12:18 PM with Resident 84 in the dining room during lunch, Resident 84 had a vegetable soup with pasta shells inside the soup bowl. Resident 84 stated she told the facility that she did not like pasta, but she still received pasta in her meals. Resident 84 had a white paper slip on the lunch tray and the white paper slip indicated Resident 84's name, diet, and no pasta. During a review of Resident 84's Admission Record dated 8/22/24, the Admission Record indicated Resident 84 admitted to the facility on [DATE] with diagnoses including but not limited to Type 2 Diabetes Mellitus (condition in which the body does not metabolize blood sugar correctly) without complications and morbid (severe) obesity (disorder involving excessive body fat that increased risk for health problems) due to excess calories. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 84's Physician History and Physical (H&P) dated 12/12/23, the H&P indicated Resident 84 had the capacity to understand and make decisions. During a review of Resident 84's Order Summary dated 8/1/24, the Order Summary Report indicated an order dated 7/15/24 for controlled carbohydrate diet (CCHO, diet that focuses on eating the same amount of carbohydrates each day to help keep blood sugar levels stable), no added salt diet, regular texture, thin consistency, non-fat milk, no pasta, soup with lunch and dinner. During a review of Resident 84's Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated 6/23/24, the MDS indicated Resident 84 had intact cognition and required set up or clean-up assistance with eating. During a review of Resident 84's Dietary Services Progress notes dated 7/15/24, the Dietary Director (DD) indicated Resident 84 wanted soup with lunch and dinner, non-fat milk, and no pasta. During a review of Resident 84's Dietary Services Progress notes dated 8/16/24, DD indicated DD reviewed food preferences and Resident 84 indicated no pasta. During a review of the facility's undated recipe for minestrone soup, the recipe indicated one of the ingredients was pasta. During an interview on 8/21/24 at 3:52 PM, DD stated the vegetable minestrone soup contained pasta inside the soup. DD stated Resident 84 did not like pasta and should not have been served pasta inside the resident's soup. DD stated the facility should honor all residents' food preferences and offer alternatives with similar nutritional value. During an interview on 8/22/24 at 4:20 PM, the Director of Nursing (DON) stated residents should not be served foods they did not like and that their food preferences should be honored. DON stated it was important to honor the resident's food preferences so that resident eat and maintain their nutrition. During a review of the facility's policy titled, Resident Food Preferences, last reviewed 4/17/24 the policy indicated the DSS will visit resident periodically to ensure food preferences are being honored.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 43418 Based on observation, interview, and record review, the facility failed to provide meals at regular times comparable to normal mealtimes in the community for one of 16 sampled residents (Resident 162) investigated under the dining observation care area when Resident 162 was served his lunch tray after the facility's scheduled lunch time. This deficient practice had the potential to affect the temperature of the food served and negatively affect the resident's psychosocial wellbeing. Findings: During a review of Resident 162's Admission Record, the Admission Record indicated the facility admitted the resident on 7/24/2024 with diagnoses including, but not limited to, type two diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]) and heart failure (a progressive heart disease that affects pumping action of the heart muscles). During a review of Resident 162's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 7/31/2024, the MDS indicated Resident 162 was able to understand and make decisions, required setup assistance to supervision with activities of daily living including eating, hygiene, dressing, mobility, and surface-to-surface transfers, and was dependent on staff for bathing or showering. During a review of Resident 162's History and Physical (H&P), dated 7/24/2024, the H&P indicated Resident 162 has the capacity to understand and make decisions and is able to make decisions for activities of daily living. During a review of Resident 162's Order Summary Report, dated 7/24/2024, the order summary report indicated Resident 162 was ordered consistent carbohydrate, no added salt, diet (specialized diet that helps keep blood sugars stable) with regular texture and thin liquid consistency. During an interview with Resident 162, on 8/21/2024, at 11:47 a.m., Resident 162 stated the food delivered to his station comes in later than the other stations. Resident 162 stated the other stations get their lunch served at 12:00 p.m. and his station gets their meals served at 1:00 p.m. Resident 162 further stated that because the meals are served late, his meals come in cold. During a concurrent observation and interview with the Activities Director (AD), on 8/21/2024, at 12:54 p.m., inside the dining room, the AD confirmed there were no residents in the dining room. The AD stated residents that decide to eat in the dining room are served lunch at 12:00 p.m., finish up around 12:45 p.m., and are brought back to their rooms so that the dining room can be cleaned for later use. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview with Resident 162, on 8/21/2024, at 1:12 p.m., a facility staff member brought a meal tray to Resident 162's room and placed the tray on the resident's bedside table. Resident 162 stated his trays are usually served around this time. During a concurrent interview and record review with the Director of Nursing (DON), on 8/23/2024, at 7:10 p. m., the facility's policy and procedure (P&P) titled, Frequency of Meals, last reviewed 4/17/2024, indicated each resident shall receive at least three meals daily, at times comparable to typical mealtimes in the community and that lunch times are between 12:00 p.m. to 12:25 p.m. The DON stated Resident 162's bedroom and the adjacent rooms had their meal trays distributed late. The DON stated it is important that residents receive their meals according to the facility's meal schedule to make sure the residents meet their nutritional needs and make sure they are all fed at the same time. The DON stated when residents are not served on time, there is a potential that the food temperatures could be affected, the residents would feel hungry, and the residents can potentially feel disrespected. During a review of the facility's P&P titled, Frequency of Meals, last reviewed 4/17/2024, the P&P indicated each resident shall receive at least three meals daily, at times comparable to typical mealtimes in the community. The P&P further indicated mealtimes for lunch are between 12:00 p.m. to 12:45 p.m.

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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. 43418 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: a. The walk-in refrigerator, walk-in freezer, and dedicated ice cream freezer did not have a thermometer separate from the built-in thermometer. b. Two dented cans were placed in the non-dented can area in the dry storage area. c. The sprinkler in the walk-in refrigerator had dust and dirt buildup. d. Mixer had dirt and dry food buildup. e. Kitchen hood had dust buildup. f. Pans in the clean area had food burned residue. These failures had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (transfer of bacteria from one object to another) in 117 of 161 medically compromised residents who received food and ice from the kitchen. Findings: a. During an observation on 8/20/2024, at 7:58 a.m., inside the kitchen walk-in refrigerator, a separate thermometer was not present. During an observation on 8/20/2024, at 8:27 a.m., inside the kitchen walk-in freezer, a separate thermometer was not present. During a concurrent observation and interview with the Dietary Director (DD), on 8/20/2024, at 8:30 a.m., inside the facility kitchen, the DD confirmed the dedicated ice cream freezer, walk-in refrigerator, and walk-in freezer did not have a separate thermometer from the built-in thermometers. The DD stated it was important to have a separate thermometer to make sure the temperature readings were correct and to have a backup thermometer in case the built-in thermometers fail. The DD stated if there is no other thermometer, there is a potential that the facility would not be able to detect if the refrigerator and freezer were not working and cause the stored food to spoil. During an interview with the Director of Nursing (DON), on 8/23/2024, at 7:10 p.m., the DON stated it is important to have a separate thermometer inside the kitchen refrigerator and freezer so that staff are aware and able to monitor the temperatures. The DON stated if the temperatures were not monitored, there was a potential that the food can become spoiled. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Refrigerator/Freezer Storage, last reviewed 4/17/2024, the P&P indicated dietary staff will check the inside temperature of refrigerators and freezers. b. During an observation on 8/20/2024, at 8:05 a.m., inside the dry storage area in the kitchen, near the canned goods storage area, one can of cream of mushroom with a label indicating a delivery date of 8/9/2024 had a dent on the lid of the can and one can of chicken noodle soup with a label indicating a delivery date of 8/16/2024 had a dent on the top of the can. During a concurrent observation and interview with the DD, on 8/20/2024, at 8:30 a.m., inside the dry storage area, near the canned goods storage area, the DD confirmed the presence of a dented can of cream of mushroom and a dented can of chicken noodle soup. The DD stated dented cans should not be stored with the undented cans. The DD stated cans are checked on delivery and sorted and placed in the designated dented can area. The DD stated it was important to sort the dented cans to avoid cross-contamination (the transfer of harmful substances or disease-causing microorganisms to food). During an interview with the DON, on 8/23/2024, at 7:10 p.m., the DON stated dented cans should be sorted and placed in the dented can area to prevent the potential spread of botulism (food poisoning caused by bacteria growing on improperly sterilized canned meats and other preserved foods) to residents. During a review of the facility's P&P titled, Storage of Canned and Dry Goods, last reviewed 4/17/2024, the P&P indicated canned items should be inspected for damage such as dented, leaking, or bulging can. The P&P further indicated these items will be stored separately in the designated area - DENTED CANS for return to the vendor or disposed of properly. A review of Food Code 2017 indicated 3-101.11 Safe Unadulterated, and Honestly Presented. Food shall be safe, unadulterated, and, as specified under 3-601.12, honestly presented. 3-201.11 Compliance with Food Law. A primary line of defense ensuring that food meets the requirements of S3-101.11 is to obtain food from approved sources, the implications of which are discussed below. However, it is also critical to monitor food products to ensure that, after harvesting, processing, they do not fail victim to conditions that endanger their safety, make them adulterated, or compromise their honest presentation. The regulatory community, industry, and consumers should exercise vigilance in controlling the conditions to which foods are subjected and be alert to signs of abuse. FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted, and pitted or dented cans may also present a serious potential hazard. c. During an observation of the fire sprinkler in the walk-in refrigerator on 8/21/2024 at 8:45 a.m., the fire sprinkler had dust and dirt buildup. During a concurrent observation of the walk-in refrigerator and interview with Dietary Director (DD) on 8/21/2024 at 8:53 a.m., DD stated the fire sprinkler had dust buildup and it was not acceptable as it could go to the resident's food. DD stated they cleaned the walk-in refrigerator daily in the morning and in the afternoon and deep cleaned it every week however, housekeeping was responsible in deep cleaning the fire sprinkler. DD stated the dirt could go to the food and residents could get sick of food poisoning, diarrhea and stomachache or infection as a potential outcome. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility's Policies and Procedures (P&P) titled Cleaning Schedule dated 4/17/2024 indicated All areas and equipment in the kitchen should be cleaned daily. A review of Food Code 2017 indicated 4-601.11 (A) Equipment Food Contact Surfaces and utensils shall be clean to sight and touch. (B) NonFood-Contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris. 47441 d. During concurrent observation of the mixer and interview with DD on 8/21/2024 at 9:11 a.m. the mixer had dry food buildup and residue. DD stated they used the mixer to make pudding and cake and it was last used on 8/19/2024, Monday. DD stated mixer must be cleaned every after use. DD stated the inside parts of the mixer had dust and dry food buildup and it was not acceptable because it was risky for the residents for cross-contamination. DD stated they used to cover the mixer with plastic when not in used and after cleaning, but they did not do it anymore due to humidity build up. A review of the facility's P&P titled Sanitizing Equipment and Surfaces dated 4/17/2024 indicated Sanitizing solution will be used to sanitize equipment and surfaces after each use or as often as needed. A review of Food Code 2017 indicated 4-601.11 (A) Equipment Food Contact Surfaces and utensils shall be clean to sight and touch. 4-701.10 Food Contact Surfaces and Utensils shall be sanitized. 4-702.11 Before use After cleaning. Utensils and Food-Contact Surfaces of Equipment shall be sanitized before use after cleaning. e. During an observation of clean pans on 8/21/2024 at 9:29 a.m., pans had burnt food residue. During a concurrent observation of the washed pans in the clean area and interview with DD on 8/22/2024 at 9:39 a.m., DD stated the buildup on the pans could be dry butter or burnt butter and it was not acceptable due to physical contamination. DD stated he would replace the pans with new pans. DS stated cross-contamination could make the residents sick of food poisoning as a potential outcome. A review of the facility's P&P titled Cleaning Schedule dated 4/17/2024 indicated The assigned dietary personnel will deep clean the area equipment assigned for them for that day using the dietary cleaning schedule. f. During a concurrent observation of the kitchen hood and interview with DD on 8/21/2024 at 9:33 a.m., the kitchen hood had dust buildup. DD stated they washed the hood filters once a week and the last time it was cleaned was last Thursday. DD stated the hood filters were dusty and dust could fall on the food in the uncovered pots and pans used for cooking. DD stated this could cause cross-contamination and fire hazard. A review of the facility's P&P titled Kitchen Hood Cleaning dated 4/17/2024 indicated Dietary staff will clean the hood on a weekly base. Hood cleaning company will perform: clean and decontaminate exhaust ducts for grease deposits and other combustible contaminants. Clean and decontaminate baffle filters for grease and other combustible contaminants. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Food Code 2017 indicated 3-307.11 Miscellaneous Sources of Contamination. Food shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301-3-306.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 47441 Based on observation, interview, and record review the facility failed to have a policy regarding the use and storage of food brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption when the policy did not include the facility's responsibility for storing food brought in by family and other visitors as it indicated The facility cannot store outside food. This deficient practice had the potential to cause a decrease food intake resulting to unintentional (without trying) weight loss, frustrations, and psychosocial harm to 117 of 161 facility residents. Findings: During a review of the facility's Policies and Procedures (P&P) untitled dated 4/17/2024, the P&P indicated Policy: This policy is for all residents in the facility in regard to outside food. Background: This policy was created to increase compliance with diet orders and prevent foodborne illness. Procedure: All food and beverage brought into the facility from outside, and those obtained from vending machines within the facility, must be cleared through the charge nurse before being given to any resident. The quantity of perishable food kept at bedside shall not be more than one meal that can easily be used by the resident within 4 hours. All foods must be kept in sealed packages or airtight containers. The facility cannot store outside food. All must meet current diet orders. During an interview with the Dietary Director (DD) on 8/21/2024 at 3:19 p.m., the DD stated he has to review the food from home policy however he was aware they were not allowed to take prepared food from the outside because the resident had no control of the temperature of the food as there were no refrigerator in the nurse's station, in the residents room and in the kitchen designated for food from the outside source. The DD stated the only food they were allowed to take from the visitors were packaged food. During an interview with Licensed Vocational Nurse 2 (LVN2) on 8/21/2024 at 3:25 p.m., LVN2 stated their procedure for resident's bringing food from the outside either coming from the visitors or relatives were as follows: (1) she checked the diet orders and allergies to ensure residents could have the food. (2) they check with the Registered Nurse (RN) Supervisors. (3) they have a refrigerator in the kitchen for resident's food storage however they did not have any storage of food in station one (1), two (2), three (3), four (4) and subacute units. (4) she would ask the kitchen staff to store the food from the outside. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN2 stated residents were allowed to bring food from the outside source as part of their resident's rights and they tried to accommodate resident's request in the best way they could as residents considered the facility their home. LVN2 stated it was important to store resident's food in the refrigerator to keep it fresh and prevent it from spoiling as it could cause food poisoning as a possible outcome. LVN 2 stated she would say no for residents who wanted to consume food a later time due to food safety. LVN 2 stated the residents could get upset and unhappy as a potential outcome of not being able to consume food later. During an interview with Director of Nursing (DON) on 8/23/2024 at 3:38 p.m., the DON stated their food from the outside policy allowed the family to bring food for one serving only as there was no personal storage or refrigerators in the resident's room or in the nurse's stations. The DON stated residents could only keep the food for four (4) hours. The DON stated it was part of the resident's rights for the residents to be allowed to bring food from outside sources however it had to be safe and refrigerated. The DON stated they would say no to residents who would not consume food within 4 hours and encouraged the resident's family to bring food in portions and come back the following day. The DON stated residents could be upset and unhappy as a potential outcome for not allowing them to bring food from the outside source to be consumed later. During an interview with the Administrator (ADM) on 8/23/2024 at 4:15 p.m., the ADM stated residents were allowed to bring from the outside and any perishable items needed to be consumed right away as they could not keep the resident's food from the outside too long. The ADM stated they gave residents a storage box for non-perishable food from outside however they did not have storage for perishable foods. ADM stated they encouraged families to bring 1 meal for single consumption. ADM stated they did not have a storage for perishable foods, but it could be stored if needed however they have a space and accessibility challenges. The ADM stated they would try to bring the residents and family what they needed like purchasing food for them. The ADM stated residents brining outside food has not been an issue.

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F 0826 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide specialized rehabilitative services by qualified personnel, when ordered for a resident by a doctor. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41379 Based on interview and record review, the facility failed to ensure Certified Occupational Therapy Assistant (COTA 1) had an active California occupational therapy (OT, rehabilitative profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) license to perform occupational therapy treatments at the facility. COTA 1's California Board of Occupational Therapy license expired [DATE] and COTA 1 continued to perform occupational therapy treatments at the facility as of [DATE]. This deficient practice resulted in an unlicensed COTA performing occupational therapy treatment for at least three months. Findings: During a review of the facility's Rehabilitation Staff Work Schedule on [DATE] at 1:25 PM, the Work Schedule indicated COTA 1 was scheduled to work [DATE], [DATE], [DATE], [DATE], and [DATE]. During a review of California Board of Occupational Therapy (CBOT) licenses for OT staff at the facility, the CBOT website indicated COTA 1's license expired [DATE]. During an interview on [DATE] at 1:41 PM, the Director of Rehabilitation (DOR) confirmed that according to CBOT website, COTA 1's California OT license was expired as of [DATE]. DOR stated according to CBOT, it was a system error, but the facility had not received anything in writing from CBOT indicating COTA 1 could continue to practice OT as of [DATE]. DOR stated COTA 1 was still working at the facility as of [DATE]. the DOR stated COTA 1 was not working at the facility today. During an interview and record review on [DATE] at 3:48 PM, the DOR provided an email from CBOT dated [DATE] indicating COTA 1's license renewal was being held and the renewal process for COTA 1's license was not complete. DOR reviewed the facility's policy on credentials validation and stated COTA 1 should not have been scheduled to work and COTA 1's access should have been deactivated on [DATE] when the facility did not receive a copy of COTA 1's active and renewed license by [DATE]. The DOR confirmed the facility continued to schedule COTA 1 to perform OT treatments as of yesterday, [DATE]. During an interview on [DATE] at 4:14 PM, the Director of Nursing (DON) stated the rehabilitation staff are contracted with a rehabilitation company. DON stated the rehabilitation company's policies were facility's policies and the facility was expected to follow the same policies. DON stated that all occupational therapists should have an active license to provide occupational therapy treatment to the facility's residents. During a review of the facility's job description for a COTA dated [DATE], the job description indicated a license as a COTA in the State of California was required. (continued on next page)

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F 0826 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy titled, Credentials Validation and Notification Guideline, dated [DATE], the policy indicated, any employee with any of the expired credentials will not be scheduled to work. HR is responsible for deactivating employee's access to the Net Health if the license is expired .employee is responsible to renew and submit all the credential to Human Resources. The policy indicated required credentials include a professional license.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44244 Based on observation, interview, and record review, the facility failed to maintain accurate and complete clinical records in accordance with accepted professional standards and practices for four of 21 sampled residents (Residents 122, 125, 138, and 6) when: a. Certified Nursing Assistant 5 (CNA 5) did not accurately document the percentage (%, a unit of measurement) of Resident 122's meal intake. b. Resident 6's August 2024 Restorative Nursing Aide (RNA, nursing aide program that help residents to maintain their function and joint mobility) Documentation Survey Report (record of nursing aide tasks) was not accurately documented when it did not indicate whether the right knee splint (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) and both ankle foot orthosis (AFO, an orthotic device designed to correct or address problems with the ankle and foot) were put on and for how long. c. Resident 6's August 2024 Restorative Nursing Weekly Summary - Splint Care was not accurately documented when it indicated Resident 6 received RNA for right knee splint seven (7) times a week when Resident 6 did not receive RNA treatment for right knee splint at least three to four times a week. d. Resident 125's July 2024 and August 2024 RNA Documentation Survey Report was not accurately documented when it indicated Resident 125 received RNA for left elbow splint and both hand rolls (device to keep fingers open) 7 times a week when Resident 125 did not receive RNA treatment for left elbow splint and both hand rolls during RNA treatment. e. Resident 138's August 2024 RNA Documentation Survey Report and Restorative Weekly Summary - Splint Care dated 8/5/24, 8/12/24, and 8/19/24 were not accurately documented when it indicated Resident 138 received RNA for left elbow splint, left resting hand splint, and right hand roll 7 times a week when Resident 138 did not receive RNA treatment for left elbow splint, left resting hand splint, and right hand roll 7 times a week. f. Resident 138's August 2024 RNA Documentation Survey Report was also not accurately documented when it did not indicate whether Resident 138 completed sitting edge of bed or range of motion exercises during RNA treatment. These deficient practices contributed to inaccurate documentation in Residents 122, 6, 125, and 138's medical charts and had the potential for inaccurate reporting of joint range of motion limitations and assessment of RNA program for Residents 6, 125, and 138 and cause a delay in provision of appropriate interventions. Findings: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. During a review of Resident 122's Admission Record, the Admission Record indicated the facility admitted the resident on 10/4/2022 with diagnoses that included metabolic encephalopathy (an alteration in consciousness due to brain dysfunction), moderate protein-calorie malnutrition (an energy deficit due to a lack of dietary protein [a nutrient needed for the body to function properly]), and unspecified dementia (general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). During a review of Resident 122's Minimum Data Set (MDS - an assessment and care screening tool) dated 7/19/2024, the MDS indicated the resident was able to understand others and was able to make herself understood. The MDS indicated the resident required setup or clean-up assistance with eating. The MDS further indicated the resident had a weight loss of five % or more in the last month or loss of ten % or more in the last six months. During a review of Resident 122's History and Physical (H&P) dated 7/12/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 122's Nutritional Amount Eaten form, dated 8/20/2024 at 1:38 p.m., the form indicated the resident ate 100 % (all) of the meal. During a concurrent observation and interview on 8/20/2024 at 12:32 p.m., Resident 122 sat in a wheelchair in the Recreation Dining Room and was self-feeding. Observed the resident did not eat the meat on the plate. Resident 122 stated she did not like the meat. During a concurrent observation and interview on 8/20/2024 at 12:45 p.m., observed Resident 122 self-propelled in her wheelchair toward the door. Observed Resident 122 stated to TN 1 that she did not like the meat. Observed TN 1 placed Resident 122's dirty tray in the meal cart. TN 1 stated Resident 122 did not eat the meat served at lunch. Observed the meat remained on Resident 122's plate. During a concurrent interview and record review on 8/20/2024 at 2:30 p.m., Certified Nursing Assistant 5 (CNA 5) reviewed Resident 122's Nutritional Amount Eaten form, dated 8/20/2024 at 1:38 p.m. CNA 5 stated she documented Resident 122 ate 100 % of lunch. CNA 5 stated she did not see Resident 122's tray and she could not remember who told her that Resident 122 ate 100% of the meal. During an interview on 8/20/2024 at 2:40 p.m., TN 1 stated that she put Resident 122's dirty tray on the meal cart and did not tell CNA 5 that Resident 122 ate 100 % of the lunch meal. TN 1 stated she told CNA 5 where Resident 122's dirty tray was located, and she thought CNA 5 would look at the tray to determine the amount eaten. TN 1 stated CNA 5's documentation that indicated Resident 122 ate 100 % of the lunch meal was not accurate and CNA 5 should not have documented if she did not know how much the resident ate. During an interview on 8/23/2024 at 12:11 p.m., the Assistant Director of Nursing (ADON) stated CNA 5 and TN 1 did not properly communicate when CNA 5 documented Resident 122 ate 100% of the lunch meal. The ADON stated CNA 5 was responsible to look at the tray to determine the amount eaten. The ADON stated a resident's chart should contain accurate information, but Resident 122's chart was not accurate when CNA 5 documented the resident ate 100%. The ADON stated when a resident's chart contains documentation of inaccurate meal percentage intake, it would create discrepancies that may potentially result in a decline in the resident's nutrition and further weight loss. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility policy and procedure titled, Charting and Documentation, last reviewed 4/17/2024, indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation in the medical record will be objective and accurate. Certified nursing assistants may only make entries in the resident's medical chart as permitted by facility policy. During a review of the facility policy and procedure titled, Resident Food Preferences, last reviewed 4/17/2024, the policy indicated nursing staff will document the resident's food intake in the chart. During a review of the Certified Nursing Assistant Job Description, approval date 8/23/2011, indicated the CNA's essential job duties and responsibilities include observing and documenting the percentage of meal intake. 41379 b.c. During a review of Resident 6's Admission Record (AR) dated 8/22/24, the AR indicated Resident 6 initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including respiratory failure (any condition that affects breathing function and result in lungs not functioning properly), Parkinson's disease (progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement) without dyskinesia (involuntary movements of extremities), and functional quadriplegia (weakness or paralysis to all four extremities). During a review of Resident 6's Order Summary Report dated 8/1/24, the Order Summary Report indicated an order dated 5/9/24 for RNA/Nursing Program established for active assistive range of motion (AAROM, movement at a given joint with a person's own effort and assistance from an external force or another person) for both UE (BUE), passive range of motion (PROM, movement at a given joint with full assistance from another person) for both LE (BLE) as tolerated followed by right knee splint, and both AFOs for four to six (4-6) hours or as tolerated, once a day, 7 times a week. During a review of Resident 6's care plan dated 5/9/24, the care plan indicated Resident 6 had limitations in range of motion and contractures (loss of motion of a joint). The care plan goal was to minimize complications related to decreased mobility or contractures through appropriate interventions through the next assessment. The care plan interventions indicated restorative nursing for AAROM to BUE, PROM to BLE, right knee splint and both AFOs for 4-6 hours or as tolerated 7 times a week, and orthotic application and skin integrity management. During a review of Resident 6's Documentation Survey Report for RNA intervention/task dated August 2024, the RNA report indicated Resident 6 completed 15 minutes of PROM 7 days a week. The RNA report did not indicate when Resident 6 did or did not wear the right knee splint or AFOs. During a review of Resident 6's Restorative Nursing Weekly Summary - Splint Care dated 8/2/24, the Splint Care Weekly Summary indicated Resident 6 had right knee splint and both AFO with a wearing schedule of four to six hours in AM. The Splint Care Weekly Summary indicated not applicable to questions in other, refuses to wear, resident takes off, and indicated no for change of condition. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 6's Restorative Nursing Weekly Summary - Splint Care dated 8/9/24, the Splint Care Weekly Summary indicated Resident 6 had right knee splint and both AFO with a wearing schedule of four to six hours in AM. The Splint Care Weekly Summary indicated not applicable to questions in other, refuses to wear, resident takes off, and indicated no for change of condition. During a review of Resident 6's Restorative Nursing Weekly Summary - Splint Care dated 8/16/24, the Splint Care Weekly Summary indicated Resident 6 had right knee splint and both AFO with a wearing schedule of four to six hours in AM. The Splint Care Weekly Summary indicated not applicable to questions in other, refuses to wear, resident takes off, and indicated no for change of condition. During a concurrent observation and interview on 8/22/24 at 9:24 AM with Restorative Nursing Aide (RNA 1) of Resident 6's RNA treatment session in Resident 6's room, RNA 1 stated Resident 6 had an RNA order for AAROM for BUE and PROM for BLE and a right knee splint and both AFOs. RNA 1 removed a white hand mitten from Resident 6's right hand and started to bend and straighten Resident 6's right knee. Resident 6's right knee was in a fully bent position and RNA 1 could straighten the right knee a little. RNA 1 moved the right leg outward and in towards the body, and ankle away and towards the body. RNA 1 was able to move the ankles a little. RNA 1 stated Resident 6 had pain with moving lower extremity so RNA 1 would try the upper extremity. RNA 1 attempted to straighten right elbow which were in bent position. RNA 1 stated Resident 6 was resisting, stopped the RNA treatment, left the room, and reported to Licensed Vocational Nurse (LVN 5). RNA 1 returned to Resident 6's room and stated RNA 1 would put on the AFOs. RNA 1 attempted to move left arm up, stated Resident 6 was resistive and stopped. RNA 1 retrieved both AFOs from cabinet and put on both ankles/feet. RNA 1 retrieved a blue right knee splint, attempted to straighten the right knee, stated Resident 6 was resisting and did not put right knee splint on. LVN 5 entered the room and RNA 1 reported to LVN 5 that Resident 6 could not put on the right knee splint. RNA 1 stated Resident 6 was able to wear the right knee splint yesterday for about four to six hours, but usually Resident 6 could not wear the knee splint about four times a week. During a concurrent interview and record review on 8/22/24 at 9:52 AM, RNA 1 stated on 8/18/24 Resident 6 did not tolerate the right knee splint. RNA 1 reviewed RNA daily task documentation on 8/18/24 and stated no, he did not document that Resident 6 did not tolerate the right knee splint. RNA 1 stated he did not report this to the charge nurse. RNA 1 reviewed RNA Weekly Summary for Splint Care dated 8/16/24 and stated he did not document that Resident 6 did not tolerate the right knee splint for at least one day. RNA 1 stated Resident 6 had not been tolerating the right knee splint about three to four times a week for many weeks but could not remember for how long. RNA 1 stated he should have documented and reported to nursing and rehabilitation department whenever Resident 6 did not tolerate any part of the RNA treatment, including when Resident 6 was resisting range of motion and ROM could not be completed or could not wear the right knee splint. RNA 1 stated it was important to document what happened daily during RNA treatment because documentation needed to be accurate and he would not remember how many times a week Resident 6 did not wear the splint in order to document the RNA Weekly Summary accurately. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/21/24 at 9:55 AM, the Director of Rehabilitation (DOR) reviewed Resident 6's RNA daily documentation and stated if the RNA completed the whole RNA treatment order, then they just answer the questions for the daily RNA task, but if the RNA did not complete any part of the RNA treatment order, then the RNA would document that separately. DOR stated the RNA daily documentation for Resident 6 did not have a question on whether RNAs put on the right knee splint or both AFOs and how long they put on the splints for. DOR stated it was important for RNAs to document how long a resident was tolerating the splints, because the RNA documentation was information staff reviewed to see if a resident was tolerating the splint, if the splint still fit, if the resident was getting worse. During an interview and record review on 8/22/24 at 2:36 PM with Registered Nurse (RN 1) and Registered Nurse (RN 5), Resident 6's clinical records were reviewed. RN 1 and RN 5 stated they were both the RN supervisors for Resident 6. RN 1 and RN 5 reviewed Resident 6's orders and stated Resident 6 had an RNA order for AAROM BUE, PROM BLE, R knee splint and both AFOs for 4-6 hours or as tolerated 7 days a week. RN 1 and RN 5 stated if Resident 6 could not tolerate any part of the RNA program, then the RNAs should document that the resident could not tolerate the RNA treatment. After a review of Resident 6's RNA documentation, RN 1 and RN 5 stated the RNAs did not document that Resident 6 did not tolerate any part of the RNA program. During an interview on 8/22/24 at 2:56 PM, the Certified Nursing Assistant (CNA 1) he was a regular CNA for Resident 6. CNA 1 stated sometimes Resident 6 had a right knee splint and sometimes Resident 6 did not. CNA 1 stated Resident 6 did not wear a right knee splint every day. During an interview on 8/22/24 at 4:41 PM, the Director of Nursing (DON) stated the RNA program was a restorative nursing program to help make sure the mobility of residents was maintained. DON stated if the RNAs were not following the RNA order, then there was a risk of decline in function for the residents. DON reviewed Resident 6's August 2024 RNA Documentation Survey Report and August RNA Weekly Summary - Splint Care and stated the RNA documentation was not accurate, because the RNA did not complete the whole order and did not document whether the splint was put on and for how long. DON stated documentation should be accurate and complete. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, last reviewed 4/17/24, the P&P indicated all services provided to the resident, progress toward the care plan goals, or any changes in physical, functional or psychosocial condition shall be documented in the resident's medical record .The following information is to be documented in the resident medical record: treatments or services performed, changes in the resident's condition .Documentation in the medical record will be objective, complete, and accurate .documentation of procedures and treatments will include care-specific details, including how the resident tolerated the procedure/treatment, whether the resident refused the procedure/treatment. During a review of the facility's policy and procedure titled, Restorative Nursing Program, last reviewed 4/17/24, the P&P indicated weekly assessments are to be made of the resident's progress in the RNP by the restorative nurse and documented in the resident's medical record. Any change in the resident's condition or response to treatment is reported to nursing and documented in the medical record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. During a review of Resident 125's AR dated 8/22/24 indicated Resident 125 initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including, but not limited to acute and chronic respiratory failure, acquired absence of right leg above knee, acquired absence of left leg above knee, hemiplegia (weakness to one side of the body) affecting left nondominant side. During a review of Resident 125's Order Summary Report dated 8/1/24, the Order Summary Report indicated an order dated 4/11/24 for RNA/Nursing program for PROM for BUE and BLE as tolerated followed by both hand rolls, both AFOs, and left elbow splint for 4-6 hours or as tolerated, once a day, 7 times a week. During a review of Resident 125's care plan dated 4/11/24, the care plan indicated Resident 125 had limitations in range of motion and contractures. The care plan goal was to minimize complications related to decreased mobility or contractures through appropriate interventions through the next assessment. The care plan interventions indicated restorative nursing for PROM for BUE and BLE, splinting with both hand rolls, and left elbow splint for 4-6 hours or as tolerated 7 times a week, with orthotic application and skin integrity management for BUE. During a review of Resident 125's Documentation Survey Report for RNA intervention/task dated July 2024, the RNA report indicated Resident 125 put on a splint every day (except 7/6/24) for either 4 or 6 hours. The RNA report did not indicate what splint was put on (left elbow splint or right or left hand rolls and time each splint was worn). The RNA report did not indicate if Resident 125 completed PROM exercises for BUE or BLE. During a review of Resident 125's Documentation Survey Report for RNA intervention/task dated August 2024, the RNA report indicated Resident 125 put on a splint every day (except 8/15/24) for either 2,4, or 6 hours. The RNA report did not indicate what splint was put on (left elbow splint or right or left hand rolls and time each splint was worn). The RNA report did not indicate if Resident 125 completed PROM exercises for BUE or BLE. During an observation and interview on 8/22/24 at 8:13 AM with Restorative Nursing Aide (RNA 2) of Resident 125's RNA treatment session in Resident 125's room, RNA 2 bent and straightened Resident 125's left elbow. RNA 2 was able to straighten the left elbow to about halfway. RNA 2 completed PROM to both UE and lifted both amputated legs up and down. RNA 2 completed the PROM exercises and did not put on any splints or hand rolls on Resident 125 during the RNA treatment session. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 8/22/24 at 8:32 AM with RNA 2, RNA 2 stated he worked with Resident 125 a lot because they were assigned certain stations and residents. RNA 2 stated he performed PROM with Resident 125 every day and RNA 2 stated he did not think Resident 125 had any splints because Resident 125's hands were not contracted. RNA 2 reviewed Resident 125's RNA orders and RNA documentation and stated Resident 125 had an RNA order for PROM for BUE and BLE followed by both hand rolls and left elbow splint for 4-6 hours as tolerated seven times a week. RNA 2 stated he was not putting hand rolls of left elbow splint on Resident 125, because he thought Resident 125 graduated from that. RNA 2 confirmed Resident 125 had an order to put on a left elbow splint and both hand rolls and that Resident 125 should wear the elbow splint and hand rolls. RNA 2 confirmed the RNA daily documentation indicated that RNA 2 was putting on the splint every day. RNA 2 stated that he should have put N/A if he was not putting on the elbow splint or hand rolls. RNA 2 stated he should have documented whenever he reported to nursing and DOR that Resident 125 did not put on elbow splint and hand rolls. RNA 2 confirmed he continued to document in RNA daily task that he spent 15 min putting on splints and that Resident 125 tolerated the splints for 4 or 6 hours. RNA 2 stated that the documentation was not accurate and did not reflect what RNA 2 completed with Resident 125 during RNA treatment. During an interview and record review on 8/22/24 at 10:57 AM, Registered Nurse (RN 4) stated the purpose of the RNA program was for RNAs to perform ROM and put splints on the residents in order to prevent contractures. RN 4 stated the RNAs should follow and complete the orders for RNA program for each resident. RN 4 stated that if the resident could not put on a splint for any reason as ordered, then the RNA should report it so it could be documented. RN 4 stated she was not aware that Resident 125 was not wearing the splints or hand rolls. RN 4 stated the RNA documentation should reflect that Resident 125 was not wearing the elbow splint or hand rolls. RN 4 reviewed the RNA documentation in August 2024 and stated the RNA documentation indicated Resident 125 was wearing the splint every day. RN 4 stated it was important to document correctly to show if the resident was getting worse or better and to show what actually happened. RN 4 stated RNAs should be documenting not applicable if they were not putting on the splints or hand rolls. During an interview on 8/22/24 at 4:27 PM, DON stated RNAs should be following the RNA orders and report if Resident 125 was not tolerating or completing any part of the RNA order. DON stated the RNA documentation was not accurate since May 2024 since the RNAs were not putting on the splints and hand rolls. DON stated documentation should be accurate and complete. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, last reviewed 4/17/24, the P&P indicated all services provided to the resident, progress toward the care plan goals, or any changes in physical, functional or psychosocial condition shall be documented in the resident's medical record .The following information is to be documented in the resident medical record: treatments or services performed, changes in the resident's condition .Documentation in the medical record will be objective, complete, and accurate .documentation of procedures and treatments will include care-specific details, including how the resident tolerated the procedure/treatment, whether the resident refused the procedure/treatment. During a review of the facility's policy and procedure titled, Restorative Nursing Program, last reviewed 4/17/24, the P&P indicated weekly assessments are to be made of the resident's progress in the RNP by the restorative nurse and documented in the resident's medical record. Any change in the resident's condition or response to treatment is reported to nursing and documented in the medical record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e.f. During a review of Resident 138's AR dated 8/22/24, the AR indicated Resident 138 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including but not limited to chronic respiratory failure, intracerebral hemorrhage (bleeding in the brain). During a review of Resident 138's Order Summary Report dated 8/1/24, the Order Summary Report indicated an order dated 7/1/24 for RNA/Nursing Program for active range of motion (AROM, movement at a given joint when the person moves voluntarily) or AAROM for BUE and BLE as tolerated followed by sitting at edge of bed as tolerated followed by left resting hand splint, left elbow extension splint, and right hand roll for 4-6 hours or as tolerated, once a day, seven times a week. During a review of Resident 138's care plan dated 7/1/24, the care plan indicated Resident 138 had limitations in range of motion and contractures. The care plan goal was to minimize complications related to decreased mobility or contractures through appropriate interventions through the next assessment. The care plan interventions indicated restorative nursing for AAROM to BUE and BLE, left resting hand splint, left elbow extension splint and right hand roll for 4-6 hours or as tolerated seven times a week, and orthotic application and skin integrity management, and sitting at edge of bed as tolerated. During a review of Resident 138's Documentation Survey Report for RNA intervention/task dated August 2024, the RNA report indicated Resident 138 tolerated a splint for 4 hours on 8/16/24, 8/17/24, 8/18/24, 8/19/24, 8/20/24, and 8/21/24. The RNA report did not indicate which splint was put on for 4 hours, if ROM exercises were completed, or if sitting edge of bed activity was completed. During a review of Resident 138's Restorative Weekly Summary - Splint Care dated 8/5/24, the RNA Weekly Summary indicated no for splint, yes for hand roll, not applicable for hand/arm splint with a wearing schedule of 4-6 hours in AM. The RNA Weekly Summary indicated no for refuses to wear, no for resident takes off, no for change of condition, no for charge nurse notified. During a review of Resident 138's Restorative Weekly Summary - Splint Care dated 8/12/24, the RNA Weekly Summary indicated no for splint, yes for hand roll, not applicable for hand/arm splint with a wearing schedule of 4-6 hours in AM. The RNA Weekly Summary indicated no for refuses to wear, no for resident takes off, no for change of condition, no for charge nurse notified. During a review of Resident 138's Restorative Weekly Summary - Splint Care dated 8/19/24, the RNA Weekly Summary indicated no for splint, yes for hand roll, not applicable for hand/arm splint with a wearing schedule of 4-6 hours in AM. The RNA Weekly Summary indicated no for refuses to wear, no for resident takes off, no for change of condition, no for charge nurse notified. During an observation and interview on 8/21/24 at 1:52 PM in Resident 138's room, Resident 138 stated he used to wear a left elbow splint, but they stopped putting it on. Resident 138 proceeded to use his right arm to grab his left wrist and attempted to straighten his left arm but could not fully straighten the left elbow. Resident 138 stated he used to have a hand roll for the left hand, but it got lost and he never received another one. Resident 138 was able to open the left hand and straighten the left fingers. Resident 138 stated he received his exercises but not the splints or hand rolls. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 8/22/24 at 8:32 AM, RNA 2 stated he performed AAROM for BUE and BLE and sitting edge of bed with Resident 138. RNA 2 stated sometimes he put on the hand roll and left elbow splint and sometimes Resident 138 wore the splint and hand roll for 1-2 hours. RNA 2 stated if Resident 138 only wore left elbow splint and hand roll for 1-2 hours, then he should document it. RNA 2 stated if Resident 138 did not wear the splints or hand roll, then he should document that Resident 138 did not wear the splints. RNA 2 reviewed the August 2024 RNA treatment record and stated the August 2024 RNA documentation showed Resident 138 wore the splints every day for 4 hours. RNA 2 stated it was not documented that Resident 138 only wore the left elbow splint and hand roll for 1-2 hours. RNA 2 stated there was no place to document if Resident 138 completed ROM or sat edge of bed. RNA 2 stated Resident 138 did not complete sitting edge of bed exercises every day, but there was nowhere to document that. During an interview and record review on 8/22/24 at 11:15 AM, RN 4 stated she was not aware of Resident 138 not wearing or tolerating the elbow splint or hand rolls. RN 4 stated she did not see Resident 138 wearing an elbow splint or hand splints. RN 4 stated Resident 138 was alert and oriented and was able to tell you if he put on an elbow splint, hand splint, or hand rolls. RN 4 reviewed Resident 138's RNA daily documentation in August 2024 and stated the RNA documentation indicated the resident was wearing the splints for 4 hours on 8/21/24. RN 4 stated if Resident 138 was wearing the splint for only 1 hour, then the documentation should indicate the resident wore it for 1 hour and not 4 hours. RN 4 stated the RNA documentation was not accurate. RN 4 stated the documentation should be accurate because we would think Resident 138 was wearing the splint for 4 hours, but in reality, he was only wearing it for 1 hour so we are not getting accurate information for assessments and to make decisions on his care. During an interview on 8/22/24 at 4:35 PM, DON stated RNA program was a restorative nursing program to help make sure the mobility of residents was maintained. DON stated if the RNAs were not following the RNA order, then there was a risk of decline in function for the residents. DON stated the RNA documentation for Resident 138 was not accurate and RNAs should not put 4 hours if the RNA was not putting on the splints or only putting on splints for 1 hour. DON stated the RNA should report to nursing anytime they were not following the RNA order for any reason. DON also stated there was nowhere in the RNA documentation to document if the resident completed the edge of bed exercises or ROM, it only indicated if the resident put on the splint and for how long. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, last reviewed 4/17/24, the P&P indicated all services provided to the resident, progress toward the care plan goals, or any changes in physical, functional or psychosocial condition shall be documented in the resident's medical record .The following information is to be documented in the resident medical record: treatments or services performed, changes in the resident's condition .Documentation in the medical record will be objective, complete, and accurate .documentation of procedures and treatments will include care-specific details, including how the resident tolerated the procedure/treatment, whether the resident refused the procedure/treatment. During a review of the facility's policy and procedure titled, Restorative Nursing Program, last reviewed 4/17/24, the P&P indicated weekly assessments are to be made of the resident's progress in the RNP by the restorative nurse and documented in the resident's medical record. Any change in the resident's condition or response to treatment is reported to nursing and documented in the medical record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections by failing to ensure: 1. One of one sampled resident's (Resident 74) oxygen's tubing was not touching the floor investigated during a random observation. 2. Licensed Vocational Nurse 1 (LVN 1) tied the gown at the waist before performing care to residents (Resident 89, 119 and 157) who were place on enhanced barrier precaution (an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities) during review of infection control task. 3. Linen carts A, B, C were not covered with a loosely woven/permeable (having pores or openings that permit liquids or gases to pass through) material to protect the linens inside the cart observed during infection control task. 4. The facility has at least two weeks supply of surgical mask during review of infection control task. 5. The water temperature in the facility was above 113 degrees Fahrenheit (a scale for measuring temperature) per Centers for Disease Control and Prevention (CDC, a US federal government agency that works to protect public health) guidelines to prevent the growth of Legionella (a severe form of pneumonia) during review of infection control task. 6. One of five sampled residents (Resident 121) investigated under the urinary catheter (a flexible tube used to empty the bladder) or urinary tract infection (UTI - an infection in any part of the urinary system [kidneys, bladder, or urethra])) care area did not have their urinary catheter bag (a bag used to collect urine from a connected urinary catheter) touching the floor when Resident 121's urinary catheter bag was observed touching the floor on 8/20/2024. 7. a. One of one sampled resident's (Resident 30) handheld nebulizer (HHN - a medical device that turns liquid medication into a very fine mist that a person can inhale through a face mask or mouthpiece) tubing was not touching the floor investigated during a random observation. b.One of one sampled resident's (Resident 30) oxygen concentrator (a machine that uses the air around you to make oxygen) was free of light brown colored material on top of the unit investigated during a random observation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. Certified Nursing Assistant 2 (CNA 2) was wearing a gown while providing activities of daily living (ADL - basic tasks that must be accomplished every day for an individual to thrive) care to a resident (Resident 111) who was on enhanced barrier precautions (EBP - refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO - microorganisms, mainly bacteria, that are resistant to one or more classes of antimicrobial agents] that requires gown and glove use during high contact resident care activities) investigated during a ramdom observation. Findings: 1. During a review of Resident 74's Admission Record, the Admission Reord indicated the facility admitted the resident on 5/11/2024, and readmitted the resident on 5/23/2024, with diagnoses including tracheostomy (an opening surgically created through the neck into the trachea [windpipe] to allow air to fill the lungs), dementia (a group of neurological conditions that affect the brain and cause a loss of cognitive functioning), and transient ischemic attack (a stroke that lasts only a few minutes). During a review of Resident 74's History and Physical (H&P), dated 5/23/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 74's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/18/2024, the MDS indicated the resident rarely to never had the ability to make self-understood and sometimes understand others. During a review of Resident 74's Order Summary Report, dated 7/22/2024, the resport indicated an order for [RT] 5 liters per minute (LPM, the rate at which one liter of matter crosses a given surface during a period of time) oxygen (O2) via T-Piece /T-Collar/M-Mask/Cool Aerosol (an instrument used in weaning of a resident from ventilator during spontaneous breathing trials) as tolerated 24/7 every shift. During a review of Resident 74's Care Plan (CP) titled, Resident is at risk for Coronavirus Disease 2019 (COVID-19 -a highly contagious disease spread from person to person through droplets released when an infected person coughs, sneezes, or talks) infection due to refusal of vaccine/immunization, revised on 8/13/2024, the CP indicated to continue infection control practices to prevent the spread of infection. During a concurrent observation and interview on 8/20/2024, at 11:49 a.m., with Licensed Vocational Nurse 7 (LVN 7), inside Resident 74's room, observed the oxygen tubing of the resident touching the floor. LVN 7 stated the tubing should not be touching the floor to prevent ascending infection to the resident. During an interview on 8/23/2024, at 7:10 p.m., with the Director of Nursing (DON), the DON stated the oxygen tubing should not be touching the floor to prevent infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's recent policy and procedure (P&P) titled, Infection Prevention and Control Program, last reviewed on 4/17/2024, the P&P indicated an infection control prevention and control program (IPCP) is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection. 2. During a review of Resident 89's Admission Record, the Admission Record indicated the facility admitted the resident on 3/14/2019, and readmitted the resident on 5/6/2024, with diagnoses including respiratory failure (a serious condition that makes it hard to breathe on your own), tracheostomy, and history of COVID-19. During a review of Resident 89's H&P, dated 5/7/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 89's MDS, dated [DATE], indicated the resident had the ability to make self-understood and understand others. The MDS indicated the resident has an order tracheostomy care (a procedure performed routinely to keep the flange, tracheostomy dressing, ties, or straps, and surrounding are clean to reduce the introduction of bacteria into the trachea and lungs). During a review of Resident 89's Order Summary Report, dated 6/25/2024, the report indicated an order for Enhanced Barrier Precaution every shift. During a review of Resident 89's Care Plan titled, Enhanced Barrier Precaution, last revised on 6/24/2024, the CP indicated an intervention to provide Enhanced Barrier precaution gloves, gowns, masks. During a review of Resident 119's Admission Record indicated the facility admitted the resident on 1/3/2023, with diagnoses including respiratory failure and tracheostomy. During a review of Resident 119's H&P, dated 1/3/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 119's MDS, dated [DATE], indicated the resident rarely to never had the ability to make self-understood and understand others. The MDS indicated the resident had a stage 3 pressure injury (a full-thickness loss of skin that exposes adipose [fat]) and was on suctioning, tracheostomy care, and on an invasive mechanical ventilator (a lifesaving procedure that uses tube to deliver positive pressure air to a resident's lungs to help them breathe). During a review of Resident 119's Order Summary Report, dated 6/25/2024, indicated an order for On Enhanced Barrier Precautions every shift. During a review of Resident 119's Care Plan titled, Enhanced Barrier Precaution, last revised on 6/24/2024, the CP indicated an intervention to provide Enhanced Barrier precaution gloves, gowns, masks. During a Review of Resident 151's Admission Record, the Admission Record indicated the facility admitted the resident on 6/5/2024, with diagnoses including acute respiratory failure, tracheostomy, and gastrostomy. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 151's H&P, dated 6/8/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 151's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others. The MDS indicated the resident was on a feeding tube (a flexible plastic tube that is inserted into the gastrointestinal tract to provide nutrition, fluids, medicines, or to remove stomach contents) and had an unstageable- deep tissue injury (a full-thickness tissue loss where the base of the ulcer is covered by dead tissue, making it difficult to determine the stage of the injury), suctioning, tracheostomy care, and on an invasive mechanical ventilator. During a review of Resident 151's Order Summary Report, dated 6/25/2024, the order indicated an order for Enhanced Barrier Precautions every shift. During a review of Resident 151's Care Plan titled, Enhanced Barrier Precaution, last revised on 6/24/2024, the CP indicated an intervention to provide Enhanced Barrier precaution gloves, gowns, masks. During a concurrent observation and interview on 8/22/2024, at 8:39 a.m., with LVN 1, inside Residents 89, 119, and 151's room, observed LVN 1 administering medication to residents who were placed on enhanced barrier precaution, wearing a gown that was untied at the waist. LVN 1 stated he should have tied the gown at the back of the waist to ensure he was protected from splashes and contact from the residents' contaminated environment. LVN 1 stated not tying the gown at the waist exposes him from splashes and sprays while giving medication to gastrostomy tubes (a tube inserted through the wall of the abdomen directly into the stomach). During an interview on 8/23/2024, at 7:10 p.m., with the DON, the DON stated LVN 1 should have tied the gown at the waist to ensure protection from splashes and spills. During a review of the facility provided CDC's Sequence for Putting on Personal Protective Equipment (PPE, clothing or equipment that people wear to reduce the risk of injury and illness from exposure to hazards in the workplace), undated, it indicated the type of PPE used will vary based on the level of precautions required, such as standard (barriers that separate people from germs to prevent the spread of microorganism in healthcare and residential settings) and contact (used to prevent the spread of diseases that can be spread through contact with open wounds), droplet (steps that healthcare facilities take to prevent the spread of germs from patients who have infections that can be transmitted through coughing, sneezing, or talking) , or airborne (a way to isolate patients who are infected with airborne pathogens that can spread through droplet nuclei) infection isolation precautions. The procedure for putting on and removing PPEs should be tailored to the specific type of PPE. 1. Gown -Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back -Fasten in back of neck and waist. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a concurrent observation and interview on 8/22/2024, at 8:23 a.m., with Treatment Nurse 3 (TN 3), on the unit hallway, observed linen CART C covered with loosely woven/ permeable cover to protect the clean linens inside the cart. TN 3 stated the cover had tiny holes that bacteria and viruses could go through, and liquid can permeate the cover and will not totally protect the linens from environmental contaminants. During a concurrent observation an interview on 8/22/2024, at 9:28 a.m., with Registered Nurse 4 (RN 4), on the unit hallway, observed linen CART A&B covered with loosely woven/permeable cover to protect the clean linens inside the cart. RN 4 stated the cover was not totally protecting the linens inside the carts as air and water can penetrate the cover. RN 4 stated viruses and bacteria were minute and can penetrate the cover and settle on the linen causing infection to residents. During an interview on 8/22/2024, at 9:31 a.m., with the Maintenance Supervisor (MS), the MS stated the covers for the linens were not totally protecting the linens from environmental contaminants because air and water can seep through the covers. During an interview on 8/23/2024, at 7:10 p.m., with the DON, the DON stated they should use non-permeable cover to protect the clean linens and to prevent spread of infection. During a review of the facility's recent policy and procedure (P&P) titled, Infection Prevention and Control Program, last reviewed on 4/17/2024, the P&P indicated an infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. During a review of the facility's recent policy and procedure titled, Laundry and Bedding, Soiled, last reviewed on 4/17/2024, indicated clean linen is protected from dust and soiling during transport and storage to ensure cleanliness. 4. During an observation, interview, and record review on 8/22/2024, with the Central Supply Staff (CSS), inside the Central Supply Room, reviewed the facility's spread sheet of PPE supplies. The CSS stated the burn rate (average consumption rate) for surgical mask per day was 900 pieces. The CSS stated they should have at least 2 weeks supply of PPEs in the facility. The CSS calculated the number of surgical masks needed for 2 weeks and stated he needed to have 12,600 pieces of surgical masks on hand. The CSS stated he did not have enough supply of surgical mask for 2 weeks as he only has 12 boxes or 3,600 pieces currently. The CSS stated it was important to have at least 2 weeks supply of surgical mask in the facility to prevent the spread of infection. During an interview on 8/23/2024, at 7:10 p.m., with the DON, the DON stated they should have at least 2 weeks of PPE supplies in the facility to ensure [NAME] are ready when there is an outbreak such as COVID-19. During a review of the facility's recent policy and procedure titled, Inventory Control, last reviewed 4/17/2024, it indicated our facility maintains an inventory control of our supplies and equipment. The purchasing agent is responsible for maintaining a perpetual inventory of our supplies and equipment. (continued on next page)

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	555686	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Studio City Rehabilitation Center	11429 Ventura Blvd Studio City, CA 91604

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/23/2024, at 7:10 p.m., with the DON, the DON stated they should keep the temperature of the water at the facility above 113 to ensure Legionella does not grow. During a review of the facility provided Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings by CDC, dated 2/24/2020, it indicated factors internal to buildings can lead to Legionella growth. Water temperature fluctuations: Provide conditions where Legionella grows best (77 degrees F - 113 degrees F); Legionella can still grow outside this range. 43418 6. During a review of Resident 121's Admission Record, the admission record indicated the facility originally admitted Resident 121 on 12/3/2021 and readmitted the resident on 6/16/2022 with diagnoses including, but not limited to, benign prostatic hyperplasia without lower urinary tract symptoms (enlargement of the prostate [gland surrounding the neck of the bladder] that can lead to difficulty in urination) and obstructive uropathy (disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional). During a review of Resident 121's MDS, dated [DATE], the MDS indicated Resident 121 had moderate cognitive impairment (difficulty understanding and making decisions), required supervision to maximal assistance with activities of daily living, including eating, showering/bathing, hygiene, dressing, and surface-to-surface transfers, and had an indwelling catheter. During a review of Resident 121's H&P, dated 6/10/2024, the H&P indicated Resident 121 had the capacity to understand and make decisions, and had a suprapubic catheter (a hollow flexible tube that is used to drain urine from the bladder). During a review of Resident 121's Order Summary Report, dated 5/21/2024, urinary catheter 18 French (a unit of measure for catheter tubing size) by 10 milliliters (ml - a unit of measure for volume) attached to a bedside drainage bag due to obstructive uropathy with urinary retention (inability to completely empty the bladder). During a review of Resident 121's Care Plan, last reviewed 6/19/2024, the care plan indicated Resident 121 had a care plan for alteration in urinary elimination and at risk for urinary tract infection secondary to use of urinary catheter, suprapubic catheter, due to obstructive uropathy with interventions including, but not limited to, urinary catheter care every shift and maintain proper alignment of urinary catheter to promote proper drainage. During an observation on 8/20/2024, at 10:21 a.m., inside Resident 121's room, a urinary catheter bag, connected to Resident 121, was lying on the floor with a basin lined with a white towel next to the catheter bag. During a concurrent observation and interview with Certified Nursing Assistant (CNA) 6, on 8/20/2024, at 10:23 a.m., inside Resident 121's room, CNA 6 confirmed Resident 121's urinary catheter bag was on the ground next to a basin lined with a white towel. CNA 6 stated it is important to keep a resident's urinary catheter bag in the basin to reduce contamination, which could potentially be a source for infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the DON, on 8/23/2024, at 7:10 p.m., the DON stated urinary catheters should be placed below the bladder so that it can drain. The DON further stated the urinary catheter should be placed in the basin to prevent the spread of infection and prevent the urinary catheter bag from touching the ground. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, last reviewed, 4/17/2024, the P&P indicated an infection prevention and control program is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. 43988 7. a. and b. During a review of Resident 30's Admission Record, the Admission Record indicated the facility admitted the resident on 6/6/2014 and readmitted the resident on 6/4/2024 with diagnoses including but not limited to dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), adult failure to thrive (a condition that happens when an older adult has a loss of appetite, eats and drinks less than usual, loses weight, and is less active than normal), and gastrostomy status (a surgical procedure used to insert a tube, through the abdomen and into the stomach to provide a route for tube feeding. During a review of Resident 30's History and Physical (H&P) dated 6/5/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 30's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 8/13/2024, the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and require total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 30's Order Summary Report, the report indicated: 6/25/2024: On enhanced barrier precautions every shift. 6/4/2024: albuterol sulfate nebulization solution (2.5 milligrams per milliliters (mg/ml - a unit of measurement) 0.083 percent (% - a unit of measurement three (3) ml inhale orally via nebulizer every six (6) hours for acute hypoxemic respiratory failure (severe form of respiratory failure that occurs when there is not enough oxygen in the blood). 6/4/2024: ipratropium-albuterol solution 0.5-25 mg/3 ml 3 ml inhale orally via nebulizer every four (4) hours as needed for shortness of breath or wheezing (a high-pitched whistling sound made while breathing). During a review of Resident 30's care plan (CP), the CP indicated 1. Resident is at risk for shortness of breath, irregular respiration, cough, activity intolerance, fever, nausea and vomiting, sore throat, runny nose initiated 3/19/2020 target date 10/18/2024, indicated to apply oxygen as needed/ordered as on the of the interventions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Enhanced Barrier Precaution: moderate risk for infection initiated 6/18/2024 target date 10/18/2024 with a goal to reduce risk for active infection daily for 3 months. The care plan indicated cleaning and disinfection of equipment as needed as one of the interventions. During a concurrent observation interview and record review on 8/20/2024 at 10:30 am., inside Resident 30's room with Licensed Vocational Nurse 3 (LVN 3), observed Resident 30's HHN tubing touching the floor and the oxygen concentrator had dried light brown colored materials on top of the concentrator. LVN 3 stated the oxygen tubing should not be touching the floor as the tubing was contaminated and the resident can acquire infection. LVN 3 stated the dried light brown colored materials on top the oxygen concentrator was dried feeding formula. LVN 3 stated the equipment should have been cleaned for infection control. During an interview with the Director of Nursing (DON) on 8/23/2024 at 7:45 p.m., the DON stated the Licensed Nurses (LN) are responsible for cleaning any resident equipment while in the room. The DON stated the oxygen concentrator should have been cleaned as soon as the feeding formula spilled on the equipment for infection control. The DON stated the HHN tubing should not be touching the floor as the tubing can get contaminated and resident can acquire infection. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, last reviewed on 4/17/2024, the P&P indicated an infection control prevention and control program (IPCP) is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection. 8. During a review of Resident 111's Admission Record the Admission Record indicated the facility admitted the resident on 1/11/2021 and readmitted the resident on 2/10/2021 with diagnoses including but not limited to PTSD, schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), and dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). During a review of Resident 111's History and Physical (H&P) dated 9/20/2023, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 111's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 7/18/2024, the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required supervision from staff with eating, partial/moderate assistance with upper body dressing, substantial/maximal assistance with rolling left and right, and dependent on staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 111's Order Summary Report, the report indicated: On enhanced barrier precaution every shift dated 6/18/2024. During an observation 8/20/2024 at 9:43 a.m., observed outside the residents's door a sign Indicating Enhanced Barrier Precautions. During an observation inside Resident 111's room, observed Certified Nursing Assistant 2 (CNA 2) providing ADL care to Resident 111 without wearing a gown, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/20/2024 at 9:51 a.m., with CNA 2, CNA 2 stated the sign by the door means that staff must wear a gown and gloves while providing care to residents with open wound to prevent spread of infection to other residents and/or staff. During an interview on 8/23/2024 at 10 a.m., with the DSD, the DSD stated all staff must wear a gown and gloves during high contact activities to residents who have open wounds or invasive lines. During an interview on 8/23/2024 at 7:45 p.m., with the Director of Nursing (DON), the DON stated for residents who were placed on enhanced barrier precautions, the staff should wear gown and gloves during high contact activities to protect the residents who are vulnerable and prevent cross contamination to other residents and staff. The DON stated residents who have active infection, open wounds, GTF, and/or indwelling urinary catheter are placed on enhanced barrier precautions. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, last reviewed on 4/17/2024, the P&P indicated an infection control prevention and control program (IPCP) is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection. During a review of the facility's policy and procedure titled, Enhanced Barrier Precautions. Last reviewed 4/17/2024, indicated: EBP are used as an infection prevention and control intervention to reduce the spread of multidrug resistant organisms (MDROs) to residents. EBP's employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Gowns and gloves are applied prior to performing the high contact resident care activity. Example of high contact resident care activities requiring the use of gowns and gloves for EBPs include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care.

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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** 44244 Based on observations. interviews, and record review, the facility failed to ensure that one of 65 resident rooms (room [ROOM NUMBER]) accommodated no more than four residents per room. room [ROOM NUMBER] measured 419.06 square feet and had five beds inside the room. This deficient practice had the potential to result in inadequate usable living space for the residents and working space for the healthcare staff. Findings: During an observation on 8/22/2024 at 8:15 a.m., observed room [ROOM NUMBER] to have five beds. The room had five residents residing in the room. Observed the room to have ample space for beds, overbed tables. dressers. equipment, and there was sufficient space for provision of necessary care and services. Residents reported no issues regarding room size. During interviews with staff on 8/22/2024 at 8:30 a.m., there were no concerns regarding the size of the aforementioned room. A review of the waiver letter submitted by the Administrator on 8/22/2024 indicated that room [ROOM NUMBER] had five beds. A review of the Client Accommodation Analysis Form indicated room [ROOM NUMBER] had an approved capacity of five residents. The facility submitted a written request for continued waiver. During a review of the facility policy titled, Bedrooms, last reviewed 4/17/2024, the policy indicated all residents are provided with clean, comfortable, and safe bedrooms that meet federal and state requirements.

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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** 44244 Based on observation, interview and record review, the facility failed to provide at least 80 square feet (sq. ft. - unit of measurement) per resident in multiple resident bedrooms for the three out of 65 resident rooms (rooms [ROOM NUMBER]). room [ROOM NUMBER] had 4 beds inside the room. room [ROOM NUMBER] and 23 had 3 beds inside the room. This deficient practice had the potential to result in inadequate useable living space for all the residents and inadequate working space for the health caregivers. Findings: During s review of the Request for Room Size Waiver letter dated 8/22/2024, submitted by the Administrator, the request for the three rooms was reviewed. The letter indicated the rooms did not meet the 80 square feet requirement per federal regulation. The letter indicated the resident beds were in accordance with the special needs of the residents and will not adversely affect the residents' health and safety and do not impede the ability of the residents in that room to obtain their highest practicable well-being. The following rooms provided less than 80 square feet per resident: Rooms # Beds Floor Area Sq. Ft. Sq. Ft/Resident 19 4 290.93 72.7 22 3 215.2 71.7 23 3 213.58 71.2 The minimum square footage for a 3-bed room should be 240 sq. ft. The minimum square footage for a 4-bed room is 320 sq ft. During the Resident Council meeting on 8/20/2024 at 10 a.m, no concerns were brought up by the residents regarding the size of the rooms. During the general observation of the residents' rooms on 8/20/2024 and 8/21/2024, the residents had ample space to move freely inside the rooms. There were sufficient spaces to provide freedom of movement for the residents and for nursing staff to provide care to the residents. There was also sufficient space for beds, side tables, and resident care equipment. During interviews with staff on 8/21/2024 at 3:30 p.m., there were no concerns regarding the size of rooms 19, 22, or 23. The facility submitted a written request for continued waiver. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During a review of the facility policy titled, Bedrooms, last reviewed 4/17/2024, the policy indicated all residents are provided with clean, comfortable and safe bedrooms that meet federal and state requirements. Bedrooms measure at least 80 square feet of space per resident in shared rooms, and at least 100 square feet of space in singles rooms.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 43418 Based on observation, interview, and record review, the facility failed to maintain an effective pest control program (measures to eradicate and contain common household pests [e.g., bed bugs, lice, roaches, ants, mosquitoes, flies, mice, and rats]) so that the facility is free of pests and rodents for one of three sampled residents (Resident 162) investigated under the environment care area when ants were observed inside Resident 162's room. This deficient practice had the potential to negatively affect the resident's psychosocial wellbeing and promote the spread of infection. Findings: During a review of Resident 162's Admission Record, the admission record indicated the facility admitted the resident on 7/24/2024 with diagnoses including, but not limited to, type two diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]) and heart failure (a progressive heart disease that affects pumping action of the heart muscles). During a review of Resident 162's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 7/31/2024, the MDS indicated Resident 162 was able to understand and make decisions, required setup assistance to supervision with activities of daily living including eating, hygiene, dressing, mobility, and surface-to-surface transfers, and was dependent on staff for bathing or showering. During a review of Resident 162's History and Physical (H&P), dated 7/24/2024, the H&P indicated Resident 162 has the capacity to understand and make decisions and is able to make decisions for activities of daily living. During an interview with Resident 162, on 8/21/2024, at 11:47 a.m., Resident 162 stated he has ants in his room. Resident 162 stated the facility staff cleans the rooms in the mornings, but they do not clean the room enough. Resident 162 stated after his roommates finish eating, they sometimes leave a mess, and it attracts the ants. Resident 162 further stated the ants make him feel uncomfortable and if the ants go on his food, he would not eat his food. During an observation on 8/21/2024, at 12:40 p.m., inside Resident 162's room, ants were crawling in the corner of the room, against the wall, next to a doorway leading to an outdoor area in the facility. During a concurrent observation and interview with the Maintenance Supervisor (MS), on 8/21/2024, at 4:00 p.m., inside Resident 162's room, the MS confirmed the presence of ants in the room. The MS stated housekeeping had just recently cleaned the room. The MS stated the facility's contracted pest control service came in today to perform their service. The MS stated the facility's contracted pest control service usually comes to the facility twice a month and are available as needed to perform services. The MS stated it important to not have ants in residents' rooms to prevent an infestation. The MS further stated having ants in the room can cause residents to feel uncomfortable and make the environment less homelike. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON), on 8/23/2024, at 7:10 p.m., the DON stated there should not be any ants in residents' rooms because they can be a source of infection or they can make the residents feel uncomfortable. During a review of the facility's Pest Control Service Report, dated 8/21/2024, the report indicated the pest control recommended to keep floors clean from food debris and taking trash out regularly and keeping trash containers covered to prevent pest entry and ant activity. The service report further indicated the pest findings included ants. During a review of the facility's policy and procedure (P&P) titled, Pest Control, last reviewed 4/17/2024, the P&P indicated the facility maintains an ongoing pest control program to ensure that the building is kept free of insects and rodents. The P&P further indicated maintenance services assist, when appropriate and necessary, in providing pest control services.