STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555706	A. Building B. Wing	11/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Del Amo Gardens Care Center	22419 Kent Avenue Torrance, CA 90505

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on observation, interview, and record review, the facility failed to maintain right to privacy for one of six sampled residents (Resident 25) by failing to ensure privacy curtains was long enough to cover the resident's room during wound care dressing change. This failure violated Resident 25's right to privacy and had the potential for Resident 25 feeling of embarrassment. Findings: During a review of Resident 25's Admission Record, the Admission Record indicated Resident 25 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), paroxysmal atrial fibrillation (fast, irregular heartbeat that occurs suddenly and typically last for a short time), chronic kidney disease stage 3 (kidneys are moderately damaged and are not filtering waste and fluid from the blood as it should be), pulmonary hypertension(condition that affects the blood vessels in the lungs that makes the heart work harder than normal to pump). On 7/14/2020 Resident 25 had a diagnosis of moderate protein -calorie malnutrition (state of inadequate intake of food- during resident stay in the facility). During a review of Resident 25's Minimum Dat Set (MDS- resident assessment tool) dated 11/2/2024, the MDS indicated Resident 25 had severe cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated Resident 25 was dependent (helper does all of the effort) on staff with bed mobility, bathing, toileting hygiene, personal hygiene, dressing, and transfer to and from the bed to chair. The MDS indicated Resident 25 was always incontinent of urine and stool. The MDS indicated the resident was at risk of developing pressure injury and had a Stage 1 pressure injury (intact skin with a localized area of redness and/or changes in sensation, temperature, or firmness). During an observation 11/21/1014 at 9:49 a.m., in Resident 25's room, privacy curtains was pulled by a staff before changing the wound dressing located in the coccyx (small bone at the bottom of the spine) area and left buttock of Resident 25. Observed the privacy curtains were not long enough to cover the room of Resident 25 and only covered the area in between Resident 25 and Resident 25's roommate. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/21/2024, at 10:02 a.m., with Certified Nursing Assistant (CNA 3), CNA 3 stated he noticed the privacy curtains had been short since he started working in the facility a month ago. CNA 3 stated the privacy curtains should be able to cover the resident's care area because the resident will not have privacy, and someone could walk in during the middle of provision of personal care where the resident was being cleaned or bathed. During an interview on 11/21/2024, at 10:14 a.m., with Treatment Nurse (TN 1), TN 1 stated the privacy curtains for Resident 25 had been short for a long time and was not sure if someone knew about it. TN 1 stated the privacy curtains should be completely cover the resident's care area to ensure privacy and maintain resident's dignity. During an interview on 11/23/2024, at 2:51 p.m., with Director of Nursing (DON), the DON stated privacy curtains need to cover the whole resident care area during provision of personal care to provide privacy and maintain resident's dignity. During a review of facility's policy and procedure (P&P) titled Dignity and respect dated 6/2018, the P&P indicated Residents' private space and property shall be always respected. The P&P indicated all residents will be always treated with respect and dignity.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50144 Based on observation, interview, and record review the facility failed to ensure two of 27 sampled residents (Resident 1 and Resident 49), was provided a safe, clean and homelike environment by failing to provide a room that did not have peeling paint and exposed wall on the bedroom walls. This deficient practice had the potential for Resident 1 and Resident 49 to affect the residents' dignity, mood, and violation of residents' rights to have a homelike environment. Findings: During a review of Resident 1's Admission record, the Admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and hemiparesis (a condition that causes weakness or an inability to move on one side of the body). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 11/4/2024, the MDS indicated Resident 1 had severe cognitive impairment (ability to think and reason) and was dependent on staff for activities of daily living (ADLs) such as oral hygiene, toileting, dressing, showering, and positioning. During a review of Resident 49's Admission record, the Admission Record indicated Resident 49 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a brain dysfunction due to an underlying condition that can cause confusion, memory loss and loss of consciousness) and dementia. During a review of Resident 49's MDS dated [DATE], the MDS indicated Resident 49 had severe cognitive impairment and was dependent on staff for activities of daily living (ADLs) such as oral hygiene, toileting, dressing, showering, and positioning. During an observation on 11/19/2024 at 9:35 a.m., in Resident 1 and Resident 49's room, observed peeling yellow paint and cracked wall on the wall facing the residents above the baseboards. During a concurrent observation and interview on 11/23/2024 at 12:19 p.m., with Certified Nurse Assistant (CNA) 6 in Resident 1 and Resident 49's room, CNA 6 stated the chipped paint and exposed wall did not reflect a homelike environment. CNA 6 stated maintenance should have been notified. During a concurrent observation and interview on 11/23/2024 at 12:24 p.m., with the Maintenance Supervisor/Account Manager (MS) in Resident 1 and Resident 49's room, the MS stated the wall was not intact, and the facility was working on repainting the room. The MS stated the peeling paint and exposed wall does not reflect a homelike environment. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/23/24 2:51 p.m., with the Director of Nursing (DON), the DON stated, Resident 1 and Resident 49's room should be a homelike environment. The DON stated there should not be paint that has chipped or dirty bedroom walls. The DON stated this could potentially affect the residents' dignity, the residents' mood, and violate residents' rights to have a homelike environment. During a review of the facility's policy and procedure (P&P), titled Homelike Environment, last revised 3/2023, The P&P indicated It is the responsibility of all facility staff to create a homelike environment and promptly address any cleaning needs.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on interview and record review the facility failed to ensure one of 18 sampled residents (Resident 39) unwitnessed fall that caused a right hip fracture (a break or crack in a bone), required surgical repair and hospitalization at a General Acute Care Hospital (GACH) for four days (9/10/2024 to 9/14/2024) was reported to the state agency (California Department of Public Health [CDPH]). This failure resulted in a delay of an onsite investigation by CDPH to ensure Resident 39's fall was investigated and prevent further falls. Findings: During a review of Resident 39's Admission Record, the Admission Record indicated Resident 39 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including to fracture (broken bone) of the right femur (thigh bone), legal blindness (a term used to describe a person's visual field of vision that is so limited that they are unable to see as well as most people), Alzheimer's disease, (a disease characterized by a progressive decline in mental abilities) and dementia (a progressive state of decline in mental abilities). During a review of Resident 39's History and Physical (H&P), dated 9/14/2024, the H&P indicated Resident 39 had fluctuating capacity to understand and make decisions due to dementia. The H&P indicated Resident 39 had a diagnosis of a right hip fracture and was status post (a patient's condition after a significant event such as surgery) intramedullary nailing (a surgical procedure that involves inserting a metal rod into the center of a bone to treat a fracture). During a review of Resident 39's Minimum Data Set (MDS -resident assessment tool) dated 9/19/2024, the MDS indicated Resident 39 had severely impaired cognition (ability to think, understand, learn, and remember) and never and or rarely made decisions. The MDS indicated Resident 39 needed substantial to maximal assistance (helper does more than half the effort) with eating, oral hygiene, upper body dressing, personal hygiene, rolling from left to right, moving from a sitting to lying position, the ability to stand from a sitting position, and transferring from the bed to a chair. The MDS indicated Resident 39 was dependent on staff (helper does all of the effort to complete the activity) for toileting, lower body dressing, and putting on and taking of footwear. The MDS indicated Resident 39 did not attempt to transfer on and off the toilet, transferring in and out the shower, and walking due to medical condition or safety concerns. During an interview on 11/23/2024 at 9:58 a.m., with Registered Nurse (RN) 1, RN 1 stated Resident 39 was blind in both eyes and dependent on nursing staff for feeding, bathing, and toileting. RN 1 stated Resident 39 had two falls in the past (5/2023 and 4/17/2024). RN 1 stated Resident 39 was found on the floor the morning of 9/10/2024. RN 1 stated Resident 39 was transferred to a GACH for a right hip fracture. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/23/2024 at 10:34 a.m., with RN 4, RN 4 stated on 9/10/2024 during the change of shift he was informed that Resident 39 was found on the floor at 6 a.m. and complained of right hip pain. RN 4 stated Resident 39 was found by a certified nursing assistant (CNA-unknown) sitting on the floor in between the bed of her roommate facing the wall. RN 4 stated Resident 39 had pain in the right leg and a right hip x-ray (create images of the inside of the body) was done. RN 4 stated the x-ray showed Resident 39 had a right hip fracture and Resident 39 was transferred to GACH on 9/10/2024 at 12:10 p.m., RN 4 stated Resident 39 had right hip surgery and returned to the facility on [DATE]. RN 4 stated Resident 39 had an unwitnessed fall that resulted in a fracture of the right hip. RN 4 stated Resident 39's fall was witnessed by a confused resident who was only alert and oriented to name and place. RN 4 stated an unwitnessed fall was when the staff or resident does not know what happened. RN 4 stated Resident 39's roommate was not a reliable witness because she was confused and cannot tell the details of the fall. RN 4 stated if a resident had an unwitnessed fall the resident should be assessed for any injury, the doctor and family notified. RN 4 stated if there was an injury like a fracture it should be reported to the California Department of Public Health. RN 4 stated an unusual occurrence should be reported as soon as possible and needs to be investigated right away. During a concurrent interview and record review on 11/23/2024 at 11:38 a.m., with the Program Manager (PM), Resident 39's roommate MDS was reviewed. The PM stated Resident 39's roommate's MDS dated [DATE], indicated Resident 39's roommate had a BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of nine. PM stated a BIM score of nine means moderate cognitive (thinking, reasoning, or remembering) impairment (a stage of cognitive decline where the ability to think, learn, and remember is significantly affected, interfering with daily activities). PM stated when she spoke to Resident 39's roommate after the fall the roommate stated she was in a dream like state when she was awakened by Resident 39 and does not remember seeing Resident 39's fall. During an interview on 11/23/2024 at 4:06 p.m., with the Director of Nursing (DON), the DON stated if a fall was unwitnessed, and after the investigation it does not make sense why and how the resident fell , then the fall was reportable to CDPH. The DON stated an unwitnessed fall was when nobody sees what happen and the resident was found on the floor. The DON stated she does not know exactly what happened and did not report the fall based on Resident 39's roommate's interview at the time of the fall. During a review of the facility's Fall Incident report, dated 9/10/2024, the Fall Incident report indicated, at 6 am the charge nurse was summoned by a certified nurse assistant to Resident 39's room. Resident 39 was found on the floor in a sitting position facing the wall in between the residents' bed and Resident 39's roommate. Resident 39 was assisted back to bed and complained of pain on the right hip. Resident 39's roommate was interviewed and stated Resident 39 came to Resident 39's roommate bedside while she was asleep and held her hand and both residents were startled possibly causing Resident 39 to fall. During a review of Resident 39's Change in condition Evaluation, dated 9/10/2024, the Change in condition Evaluation indicated, an x-ray was done on the right hip and resulted in an acute right hip fracture. During a review of the GACH records, titled History & Physical, dated 9/10/2024, the History & Physical indicated an intertrochanteric fracture of the right femur. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Fall Management Program, date revised 3/2023, the P&P indicated, Following comprehensive evaluation of the resident, notification of the appropriate persons, and after the resident is stable, the facility staff member in charge will complete applicable report and forward to management as indicated; or required by State law. During a review of the facility's policy and procedure (P&P) titled, Reporting Unusual Occurrences, date revised 3/2023, the P&P indicated, The facility asserts there are no requirements in the California Code of Regulations, Title 22, for facilities to report events, such as falls, or residents wandering outside of the building, unless the circumstances are unusual, as with suspected abuse or neglect. This remains true when the event results in an injury to the resident, unless the injury is unusual for the resident given the resident's current health status.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on interview and record review the facility failed to ensure Minimum Data Set Coordinator (MDSC) completed a significant change in status assessment (SCSA- a comprehensive assessment that must be completed when the Interdisciplinary Team [IDT- team of healthcare professionals who discuss and manage resident's care] has determined that a resident meets the significant change guidelines to either major improvement or decline) to one of six sampled residents (Resident 25). This failure had the potential for not providing appropriate care and services to Resident 25. Findings: During a review of Resident 25's Admission Record, the Admission Record indicated Resident 25 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), paroxysmal atrial fibrillation (fast, irregular heartbeat that occurs suddenly and typically last for a short time), chronic kidney disease stage 3 (kidneys are moderately damaged and are not filtering waste and fluid from the blood as it should be), pulmonary hypertension(condition that affects the blood vessels in the lungs that makes the heart work harder than normal to pump). On 7/14/2020 Resident 25 had a diagnosis of moderate protein -calorie malnutrition (state of inadequate intake of food- during resident stay in the facility). During a review of Resident 25's Minimum Dat Set (MDS- resident assessment tool) dated 11/2/2024, the MDS indicated Resident 25 had severe cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated Resident 25 was dependent (helper does all of the effort) on staff with bed mobility, bathing, toileting hygiene, personal hygiene, dressing, and transfer to and from the bed to chair. The MDS indicated Resident 25 was always incontinent of urine and stool. The MDS indicated the resident was at risk of developing pressure injury and had a Stage 1 pressure injury (intact skin with a localized area of redness and/or changes in sensation, temperature, or firmness). During a review of Resident 25's COC Evaluation dated 11/11/2024, timed at 3:58 p.m., the COC indicated there was a small opening in the coccyx area where the redness was observed on 10/30/2024. During a review of Resident 25's Pressure Sore Management Record dated 11/11/2024, the Pressure Sore Management Record indicated Stage II pressure injury on the coccyx measured two and half (2.5) cm. in length and two (2) cm. in width. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/22/2024, at 3:03 p.m., with Minimum Data Set Coordinator (MDSC), MDSC stated significant change in status assessment (SCSA- a comprehensive assessment that must be completed when the Interdisciplinary Team (IDT- team of healthcare professionals who discuss and manage resident's care) has determined that a resident meets the significant change guidelines to either major improvement or decline) was triggered by two major areas like weight loss and pressure injury (localized damage to the skin and/or underlying tissue usually over a bony prominence). MDSC stated when she conducted her assessment the pressure injury was Stage 1 and weight loss. MDSC stated she will review Resident 25's medical records, talk to Treatment Nurse (TN1) and will do a significant change in status assessment. MDSC stated MDS should be accurate because the information was submitted to Center of Medicare (CMS) and wrong resident's information will affect the resident's care by not receiving the proper care and treatment. During an interview on11/23/2024, at 3:40 p.m., with Director of Nursing (DON), the DON stated SCSA was triggered if a resident had two major changes in their condition. The DON stated it was important to complete SCSA to target a specific action for an identified problem. During a review of facility's policy and procedure (P&P) titled Comprehensive Assessments Timing revised 3/2023, the P&P indicated a SCSA is appropriate if there are either two or more MDS areas of decline or two or more areas of improvements or if the IDT determines that the resident would benefit from the SCSA assessment and subsequent care plan revision.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on interview and record review the facility failed to ensure two of 18 sampled Residents (Resident 39 and 68) entry on the Minimum Data Set (MDS -resident assessment tool) assessment entries were accurate. The facility failed to: a. Ensure Section M in the MDS titled Skin Conditions was accurately documented to reflect Resident 39's current skin condition. b. Ensure Resident 68 discharge status was accurately documented to reflect Resident 68 was discharged home. This failure had the potential to result in a negative effect of Resident 39 and 68's plan of care and delivery of necessary care and services. Findings: a.During a review of Resident 39's Admission Record, the Admission Record indicated Resident 39 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including fracture (broken bone) of the right femur (thigh bone), legal blindness, Alzheimer's disease, (a disease characterized by a progressive decline in mental abilities) and dementia (a progressive state of decline in mental abilities). During a review of Resident 39's History and Physical (H&P), dated 9/14/2024, the H&P indicated Resident 39 had fluctuating capacity to understand and make decisions due to dementia. The H&P indicated Resident 39 had a diagnosis of a right hip fracture and was status post (a patient's condition after a significant event such as surgery) intramedullary nailing (a surgical procedure that involves inserting a metal rod into the center of a bone to treat a fracture). During a review of Resident 39's MDS dated [DATE], the MDS indicated Resident 39 had severely impaired cognition and never and or rarely made decisions. The MDS indicated Resident 39 needed substantial to maximal assistance with eating, oral hygiene, upper body dressing, personal hygiene, rolling from left to right, moving from a sitting to lying position, the ability to stand from a sitting position, and transferring from the bed to a chair. The MDS indicated Resident 39 was dependent on staff for toileting, lower body dressing, and putting on and taking of footwear. The MDS indicated Resident 39 did not attempt to transfer on and off the toilet, transferring in and out the shower, and walking due to medical condition or safety concerns. The MDS indicated Resident 39 had a Stage II (partial-thickness loss of skin, presenting as a shallow open sore or wound) and stage III (a full-thickness tissue loss where subcutaneous fat is visible within the wound, but bone, tendon, or muscle are not exposed) pressure ulcer (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/22/2024 at 2:05 p.m., with Treatment Nurse (TN) 1, TN 1 stated Resident 39 was readmitted to the facility after surgery with Stage II pressure ulcer located at coccyx (the last bone at the bottom of the spine) on 9/14/2024. TN 1 stated Resident 39 has not developed Stage III pressure ulcer or Stage IV (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) pressure ulcer and was not receiving any wound care. TN 1 stated the Stage II pressure ulcer is resolved. During an interview on 11/22/2024 at 3:38 p.m., with Minimum Data Set Coordinator (MDSC), MDSC stated Resident 39 came to the facility with a Stage II pressure ulcer. MDSC stated the MDS was miscoded inaccurately by documenting Resident 39 had a Stage III pressure ulcer. 50144 b.During a review of Resident 68's Admission record, the Admission Record indicated Resident 68 was admitted to the facility on [DATE] with diagnoses including wedge compression fractures (type of spine fracture [broken bone] that occurs when the front of a vertebra collapses or compresses, giving it a wedge shape) of the thoracic (middle section of spine) and lumbar (lower section of spine) vertebrae (bones of the spine), fracture of the sacrum (a bony structure at the base of the lumbar vertebrae that is connected to the pelvis-hip bone), and repeated falls. The face sheet indicated Resident 68 was discharged on [DATE] to a private home with home health services. During a review of Resident 68's History and Physical (H&P), dated 10/23/2024, the H&P indicated Resident 68 did not have the capacity to understand and make decisions. During a review of Resident 68's Interdisciplinary Discharge Summary, dated 10/31/2024, the document indicated Resident 68 was discharge to home on 10/31/2024 with arranged home health services including physical therapy, occupational therapy, and registered nurse visits. During a concurrent interview and record review on 11/22/2024 at 10:03 a.m., with the MDS Coordinator (MDSC), Resident 68's MDS dated [DATE] was reviewed. The MDSC indicated Resident 68 had an unplanned discharge to a Short-Term General Hospital on 10/31/2024. The MDS nurse stated the MDS was incorrect, and the MDS should have reflected that Resident 68 was discharged home. The MDS nurse stated they will submit a correction. During an interview on 11/23/2024 at 2:51 p.m. with the Director of Nursing Services (DON), the DON stated it is important for the MDS to be accurate and reflect the resident to be able provide accurate care and services for the residents. During a review of the facility's policy and procedure (P&P) titled, Accuracy of Assessments, date revised 3/2023, the P&P indicated, The assessment must represent an accurate picture of the resident's status during the observation period of the MDS .When the MDS is completed, only those occurrences during the observation period will be captured on the assessment. In other words, if it did not occur during the observation period, it is not coded on the MDS.

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Del Amo Gardens Care Center	22419 Kent Avenue Torrance, CA 90505

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45382 Based on interview and record review, the facility failed to review and revise the comprehensive care plan for two of five sampled residents (Resident 2 and Resident 46). The facility failed to: a. Update the Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) plan of care when OT services were discontinued. This deficient practice had the potential to negatively affect the delivery of necessary care and services for Residents 2. b. Review and revise the care plan after the Resident 46 experienced a change of condition. This failure had the potential to result in Resident 46 experiencing repeated hypoglycemic (low blood sugar) events, diabetic coma (a life-threatening condition that occurs when someone with diabetes [DM a disorder characterized by difficulty in blood sugar control and poor wound healing] has dangerously high or low blood sugar and becomes unconscious), or death. Findings: a.During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including right sided hemiplegia (weakness to the right side of the body) and hemiparesis (inability to move one side of the body) following a non-traumatic intracerebral hemorrhage (bleeding in the brain) and contractures (loss of motion of a joint associated with stiffness and joint deformity) of both hands and the lower leg. During a review of Resident 2's Physician Order Summary Report, the Physician Order Summary Report indicated a physician's order, dated 6/28/2024, for OT to discontinue OT services for exercises, neuromuscular re-education (rehabilitation techniques to restore muscle function and movement), and splint (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) management. During a review of Resident 2's Care Plan titled Resident 2 had decreased balance, coordination, safety, endurance, and range of motion (ROM, full movement potential of a joint) in both hands, initiated on 6/26/2024, the Care Plan indicated interventions to address Resident 2's impairments were for OT services, three times a week for four weeks, for exercises, neuromuscular re-education (rehabilitation techniques to restore muscle function and movement), and splint management. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 10/2/2024, the MDS indicated Resident 2 had severely impaired cognitive (ability to think, understand, learn, and remember) skills for daily decision making. The MDS indicated Resident 2 was dependent in eating, hygiene, bathing, dressing, rolling to both sides, and transfers. The MDS indicated Resident 2 had functional limitations in ROM (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in both arms and both legs. During a concurrent interview and record review on 11/21/2024 at 1:06 p.m., with the Director of Rehabilitation (DOR), the DOR stated the licensed therapists which included the OTs, Physical Therapists (PT, licensed professional aimed in the restoration, maintenance, and promotion of optimal physical function), and Speech Therapists (ST, licensed professional aimed in the prevention, assessment, and treatment of speech, language, communicative, and swallowing disorders) were responsible for developing, reviewing, and revising the section of a resident's care plans related to therapy services. The DOR stated everything related to therapy should be care planned. The DOR reviewed Resident 2's care plans, physician's orders, and therapy notes. The DOR confirmed Resident 2's care plans indicated Resident 2 was receiving OT services but was not. The DOR confirmed Resident 2's care plan was not updated and stated the OT interventions should have been discontinued when Resident 2 was discharged from OT services on 6/28/2024. The DOR stated it was important care plans were revised and updated to avoid confusion and to ensure the facility was addressing the resident's care appropriately. During an interview on 11/22/2024 at 9:15 am, the Minimum Data Set Coordinator (MDSC) stated the Rehabilitation Department was responsible for developing and updating all the care plans related to therapy services. The MDSC stated it was important for care plans to be accurate and updated to ensure the resident was receiving the appropriate type of care. During an interview on 11/22/2023 at 10:14 am, the Director of Nursing (DON) stated the comprehensive care plan was a guide used by staff to identify a resident's goals and problem areas and create interventions to address those concerns. The DON stated the care plan should be updated for any change of condition, upon discovery of any new concern, quarterly, and as needed. The DON stated it was important for care plans to be accurate and updated to ensure staff knew how to provide the appropriate care to the residents. During a review of the facility's Policy and Procedure (P&P), revised 3/2023, titled Comprehensive Care Plans - Timing, the P&P indicated the residents shall have a person-centered, comprehensive care plan, developed, reviewed, and revised by the facility interdisciplinary team including the resident and resident representative, if applicable. The P&P indicated the interdisciplinary team reviewed and revised the comprehensive care plan after each assessment, including both the comprehensive and quarterly review assessments. 50144 b. During a review of Resident 46's Admission record, the Admission Record indicated Resident 46 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and osteomyelitis (inflammation of bone, usually due to infection). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 46's History and Physical (H&P), dated 9/13/2024, the H&P indicated Resident 46 had the capacity to understand and make decisions. During a review of Resident 46's Minimum Data Set (MDS - a resident assessment tool), dated 9/19/2024, the MDS indicated Resident 46 was able to understand and be understood by others. The MDS indicated Resident 46 required setup or clean up assistance for eating and oral hygiene and partial assistance (helper performs less than half of the effort) for toileting and dressing. During a review of Resident 46's Medication Administration Record (MAR) for July 2024, the MAR indicated the following orders: a.Basagalar KwikPen subcutaneous solution pen-injector 100 unit/ml (milliliter) (Insulin [a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) Glargine ((long acting type of insulin that works slowly over time]) Inject 64 unit subcutaneously (administered in the fatty tissue just under the skin layer) one time a day for DM , Start Date: 5/23/2024. b.Farxiga oral tablet five mg (milligrams) (Dapagliflozin Propandediol) Give 1 tablet by mouth one time a day for Type 2 DM, Start Date: 1/17/2024. c.NovoLin R FlexPen Injection Solution Pen-Injector 100 unit/ml (Insulin Regular (Human)) (a short acting type of insulin usually given 30 minutes prior to meal based on sliding scale parameters (the amount of insulin to be administered changes or slides up or down based on the person's blood sugar.) Inject as per sliding scale subcutaneously before meals for DM2, Start date 4/10/2024, Schedule times: 6:30 a.m., 11:30 a.m., and 4:30 p.m. d.NovoLin R FlexPen Injection Solution Pen-Injector 100 unit/ml (Insulin Regular (Human)) Inject as per sliding scale subcutaneously at bedtime for DM2, scale Start date 4/10/2024 During a review of Resident 46's Situation, Background, Assessment, Recommendation [SBAR]a communication tool used by healthcare workers when there is a change of condition among the residents) Summary dated 7/18/2024 at 8:00 a.m., the SBAR indicated Resident 46: a.Experienced confusion and skin were cold and clammy (common symptoms of hypoglycemia). b.Blood glucose (sugar) was 42 milligrams per deciliter (mg/dL -unit of measurement). c.Resident 46 was given two glasses of orange juice and 3 packets of sugar. d.One hour after orange juice administration, Resident 46's blood sugar was 80 mg/dL and was back to baseline mentation. During a review of Resident 46's Physician Order Summary dated 11/23/2024, the Order Summary indicated on 7/19/2024 at 9:38 a.m., the physician decreased Resident 46's scheduled Insulin Glargine from 64 units to 30 units. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 46's care plans, the care plan indicated Registered Nurse (RN) 4 initiated a care plan on 7/19/2024 regarding Resident 46's episode of hypoglycemia. The Care plan was cancelled on 8/29/2024 when Resident 46 was transferred to the acute care hospital. During a concurrent interview and record review on 11/23/2024 at 10:08 a.m., with Licensed Vocational Nurse (LVN) 3, Resident 46's SBAR Summary dated 8/18/2024 at 4:04 p.m. was reviewed. The SBAR indicated Resident 46: a.Experienced symptoms of increased confusion, feeling cold and clammy b.Blood glucose was checked by an LVN (TN1) and was 34 mg/dL. c.TN 1 attempted to give a glass of apple juice with 3 packs of sugar, but Resident 46 was unable to swallow. TN 1 administered glucagon (medication to increase blood glucose) 1 mg intramuscular (IM-given in the muscle). d.Blood glucose was rechecked 10 minutes after glucagon administration and was 49mg/dL e.30 minutes after glucagon administration, Resident 46 was not verbally responsive and blood glucose was 61 mg/dL. f.TN 1 gave Resident 46 a glass of orange juice with 3 packets of sugar. g.15 minutes after orange juice administration, Resident 46 became verbally responsive and blood sugar was 106. During an interview on 11/23/2024 at 10:08 a.m., with LVN 3, LVN 3 stated any situation that the resident experiences a change of condition, a care plan should be initiated or revised. During a review of Resident 46's Physician Order Summary dated 11/23/2024, the Physician Order Summary indicated on 8/18/2024 at 7:14 p.m , the physician discontinued Resident 46's scheduled Insulin Glargine 30 units. During an interview on 11/23/2024 at 10:50 a.m., with the Minimum Data Set Coordinator (MDSC), the MDSC stated Resident 46's care plans were not revised after the hypoglycemic event on 8/18/2024. The MDSC stated it was important that the care plan was revised to prevent continued hypoglycemic events. During a concurrent interview and record review on 11/23/2024 at 2:51 p.m., with the Director of Nursing Services (DON), Resident 46's electronic health record (EHR) was reviewed. The DON stated care plans should always be initiated or revised when there was a change of condition to have a clear picture of what the interventions are and what needs to be monitored. During a review of the facility's policy and procedure (P&P), titled Comprehensive Care Plans-Timing, last revised March 2023, The P&P indicated Each resident shall have a person-centered, comprehensive care plan, developed, reviewed and revised by the facility interdisciplinary team.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50144 Based on interview and record review, one of one sampled resident (Resident 46) received treatment and care when Resident 46 experienced two hypoglycemic (low blood sugar) events (7/18/2024 and 8/18/2024). The facility failed to: a.Conduct and Interdisciplinary Team (IDT- team of health care professionals that work together toward and prioritize the resident's needs) meeting after Resident 46 experienced two hypoglycemic (low blood sugar) events (7/18/2024 and 8/18/2024). b.Activate the emergency response system on 8/18/2024 when Resident 46's continues to be unresponsive after interventions. This failure had the potential to result in Resident 46 experiencing repeated hypoglycemic events, diabetic coma (a life-threatening condition that occurs when someone with diabetes [DM a disorder characterized by difficulty in blood sugar control and poor wound healing]), including death. Findings: During a review of Resident 46's Admission record, the Admission Record indicated Resident 46 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and osteomyelitis (inflammation of bone, usually due to infection). During a review of Resident 46's History and Physical (H&P), dated 9/13/2024, the H&P indicated Resident 46 had the capacity to understand and make decisions. During a review of Resident 46's Minimum Data Set (MDS - a resident assessment tool), dated 9/19/2024, the MDS indicated Resident 46 was able to understand and be understood by others. The MDS indicated Resident 46 required setup or clean up assistance for eating and oral hygiene and partial assistance (helper performs less than half of the effort) for toileting and dressing. During a review of Resident 46's Medication Administration Record (MAR) for July 2024, the MAR indicated the following orders: a.Basagalar KwikPen subcutaneous solution pen-injector 100 unit/ milliliter (mg-unit of measurement) (Insulin [a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) Glargine (long acting type of insulin that works slowly over time) inject 64 unit subcutaneously (administered in the fatty tissue just under the skin layer) one time a day for DM , with a start date of 5/23/2024. b.Farxiga oral tablet five milligrams (mg-unit of measurement) (Dapagliflozin Propandediol) give one tablet by mouth one time a day for type 2 DM, with a start date of 1/17/2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c.NovoLin R FlexPen Injection Solution Pen-Injector 100 unit/ml (Insulin Regular (Human)) (a short acting type of insulin usually given 30 minutes prior to meal based on sliding scale parameters (the amount of insulin to be administered changes or slides up or down based on the person's blood sugar.) inject as per sliding scale subcutaneously before meals for type 2 DM, with a start date of 4/10/2024, and schedule times: 6:30 a.m., 11:30 a.m., and 4:30 p.m. d.NovoLin R FlexPen Injection Solution Pen-Injector 100 unit/ml (Insulin Regular (Human)) inject as per sliding scale subcutaneously at bedtime for type 2 DM, scale with a start date of 4/10/2024. During a review of Resident 46's Situation, Background, Assessment, Recommendation [SBAR]a communication tool used by healthcare workers when there is a change of condition among the residents) Summary dated 7/18/2024 at 8:00 a.m., the SBAR indicated Resident 46: a.Experienced confusion and skin were cold and clammy (common symptoms of hypoglycemia). b.Blood glucose (sugar) was 42 milligrams per deciliter (mg/dL -unit of measurement). c.Resident 46 was given two glasses of orange juice and 3 packets of sugar. d.One hour after orange juice administration, Resident 46's blood sugar was 80 mg/dL and was back to baseline mentation. During a review of Resident 46's Laboratory (Lab) Results Report dated 7/19/2024, the Lab results report indicated Resident 46's blood glucose collected on 7/19/2024 at 4:30 a.m. was 34 mg/dL. The report indicated the results were communicated from the laboratory to registered nurse (RN) 3 on 7/19/2024 at 8:04 p.m. During a review of Resident 46's Medication Administration Record (MAR) for July 2024, the MAR indicated Resident 46's blood sugar was: a.7/19/2024 at 9:00 p.m. was 283 mg/dL b.7/20/2024 at 6:30 a.m. was 128 mg/dL. During a review of Resident 46's Physician Order Summary dated 11/23/2024, the Order Summary indicated on 7/19/2024 at 9:38 a.m., the physician decreased Resident 46's scheduled Insulin Glargine from 64 units to 30 units. During a review of Review of Resident 46's Nurse Progress Note dated 7/20/2024, the note indicated Resident 46's blood glucose level of 34 mg/dL (collected by the laboratory) was reported to the physician on 7/20/2024 at 8:42 a.m. The note indicated the physician did not provide new orders as the Insulin Glargine was decreased on 7/19/2024. During a concurrent interview and record review on 11/23/2024 at 10:08 a.m. with Licensed Vocational Nurse (LVN) 3, Resident 46's SBAR Summary dated 8/18/2024 at 4:04 p.m., Resident 46's Meal Nutrition-Meal Percentages for August 2024, and Resident 46's MAR for August 2024 were reviewed. The SBAR indicated Resident 46: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Experienced symptoms of increased confusion, feeling cold and clammy b. Blood glucose was checked by an LVN (TN1) and was 34 mg/dL. c. TN1 attempted to give a glass of apple juice with 3 packs of sugar, but Resident 46 was unable to swallow. TN 1 administered glucagon (Medication to increase blood glucose) 1 mg intramuscular (IM-given in the muscle). d. Blood glucose was rechecked 10 minutes after glucagon administration and was 49mg/dL e. 30 minutes after glucagon administration, Resident 46 was not verbally responsive and blood glucose was 61 mg/dL. f. TN 1 gave Resident 46 a glass of orange juice with 3 packets of sugar. g. 15 minutes after orange juice administration, Resident 46 became verbally responsive and blood sugar was 106. The Nutrition-Meal Percentages for August 2024 indicated on 8/18/2024, Resident 46 ate 0% of meal during lunch time (12:15 p.m.) and 0% of meal during dinner (5:15 p.m.). The MAR for 2024 indicated on 8/18/2024 at 4:45 p.m., Resident 46 received 1 unit of Insulin Regular. LVN 3 stated if the resident's blood sugar was still under 70 and the resident was symptomatic or had a decline in mentation after the administration of glucagon, the emergency response system should have been activated and 911 should have been called. LVN 3 stated because Resident 46 experienced the hypoglycemic event, the Insulin Regular scheduled to be given at 4:30 p.m. should have been clarified with the physician prior to administering even the blood glucose was within range to administer. During a review of Resident 46's Physician Order Summary dated 11/23/2024, the Physician Order Summary indicated on 8/18/2024 at 7:14 p.m , the physician discontinued Resident 46's scheduled Insulin Glargine 30 units. During an interview on 11/23/2024 at 10:50 a.m. with the Minimum Data Set Coordinator (MDSC), the MDSC stated IDT meetings did not occur after the hypoglycemic events and was not discussed during the scheduled quarterly IDT meetings. During a concurrent interview and record review on 11/23/2024 at 2:51 p.m. with the Director of Nursing Services (DON), Resident 46's chart was reviewed. The DON stated the emergency response system should have been initiated after Resident 46 experienced a decline in mentation on 8/18/2024 to prevent any delay in care. The DON stated IDT meetings should have been conducted after the hypoglycemic events to discuss the possible causes and to ensure care plan and interventions were revised to prevent reoccurrence of the hypoglycemic events. The DON stated the nurse should have clarified the insulin orders with the physician on 8/18/2024 prior to administering scheduled insulin after the hypoglycemic event. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P), titled Care and Services Residents Rights, dated November 2024, The P&P indicated The facility strives to provide residents with the necessary care and services to maintain his or her highest level of practicable functioning in an environment that enhances each resident's quality of life in the scope of a long-term care facility.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on observation, interview and record review, the facility failed to ensure a resident, who was assessed at a moderate risk (a scoring tool used to predict residents' risk of developing a pressure injury, total scores range from six to 23. A lower score indicating a higher risk of developing a pressure injury) for developing a pressure injury and had an intact skin upon admission, did not develop a Stage I (intact skin with a localized area of redness and/ or changes in sensation, temperature , or firmness) pressure injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) on coccyx area and progressed into Stage II (partial-thickness loss of skin, presenting as a shallow open sore or wound) pressure injury measuring two and half centimeter (cm-unit of measurement) in length by two cm in width and shearing (type of injury where different layers of skin or tissue slide against each other in opposite directions, causing damage to the deeper tissue layers) in the coccyx (small bone at the bottom of the spine) area to one of five sampled residents (Resident 25). The facility failed to: 1. Implement Resident 25's care plan titled Altered Skin Integrity due to actual pressure injury related to immobility and compromised nutritional status, initiated on 10/30/2024 with interventions to turn and reposition the resident to offload (minimizing or removing weight placed on the affected area to help and prevent pressure injury) the coccyx area and buttocks and low air loss mattress (designed to distribute the patient's body over a broad surface area and help prevent skin breakdown) with bolsters (a long pillow or cushion) for skin maintenance (not initiated until 11/11/2024 [11 days after Resident 25 developed a Stage I pressure injury]) to prevent Resident 25 from developing a pressure injury by relieving the pressure from the coccyx area. 2. Ensure bath towels were not used in replacement of incontinence pads (diaper) to keep Resident 25 clean and dry from incontinence of urine and stool. These failures had the potential for Resident 25's Stage II pressure injury on the left buttock delayed in healing and to progress to size and wound stage. Findings: During a review of Resident 25's Admission Record, the Admission Record indicated Resident 25 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), paroxysmal atrial fibrillation (fast, irregular heartbeat that occurs suddenly and typically last for a short time), chronic kidney disease stage 3 (kidneys are moderately damaged and are not filtering waste and fluid from the blood as it should be), pulmonary hypertension(condition that affects the blood vessels in the lungs that makes the heart work harder than normal to pump). On 7/14/2020 Resident 25 had a diagnosis of moderate protein -calorie malnutrition (state of inadequate intake of food- during resident stay in the facility). (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 25's Minimum Dat Set (MDS- resident assessment tool) dated 11/2/2024, the MDS indicated Resident 25 had severe cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated Resident 25 was dependent (helper does all of the effort) on staff with bed mobility, bathing, toileting hygiene, personal hygiene, dressing, and transfer to and from the bed to chair. The MDS indicated Resident 25 was always incontinent of urine and stool. The MDS indicated the resident was at risk of developing pressure injury and had a Stage 1 pressure injury (intact skin with a localized area of redness and/or changes in sensation, temperature, or firmness). During a review of Resident 25's Care plan titled Resident is at risk for Alteration in Skin Integrity related to diabetes, fragile skin , incontinence, anemia (low blood count), hypothyroidism, muscle weakness, moderate calorie protein malnutrition and resident refuses to turn, high risk for pressure injuries initiated on 1/28/2019, with Care plan goal included Resident 25 will remain free of avoidable altered skin integrity dated 1/28/2024 and revision on 8/8/2024. The Care plan interventions included monitoring for signs and symptoms of skin breakdown (initiated 4/20/2020), and notify the physician if present, apply skin moisturizers to dry skin, encourage and assist to offload, encourage to turn, and reposition at least every two hours while in bed and keeping Resident 25 clean and dry. During a review of Resident 25's Braden Scale (a scoring tool used to predict residents' risk of developing a pressure injury, total scores range from six to 23. A lower score indicating a higher risk of developing a pressure injury) dated 2/2/2024 the Braden Scale indicated Resident 25's score was 13 (score of 13 means moderate risk of developing pressure injury). During a review of Resident 25's Change of Condition Evaluation (COC- a sudden clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional condition) dated 10/30/2024 timed at 4:42 p.m., the COC indicated Resident 25 had developed redness on the coccyx area. During a review of Resident 25's Care Plan titled Altered Skin Integrity due to actual pressure injury related to immobility and compromised nutritional status, initiated 10/30/2024. The Care Plan indicated on 11/11/2024 the pressure injury progressed to Stage II and on 11/12/2024 the wound specialist physician clarified wound site as located in the left buttock. The Care Plan goal indicated Resident 25's pressure injury will show signs of healing and remain free of infection. The Care Plan interventions included encourage Resident 25 to turn and reposition every two hours and as needed due to resident's preference to lay on her back, low air loss mattress with bolsters for skin maintenance, provide supplemental proteins, vitamins, minerals as ordered, provide diet and supplements and Registered Dietician to assess nutritional needs to promote wound healing. The Care Interventions indicated to provide perineal care (the practice of cleaning the genital and anal area) with each incontinence episode, and monitor wound dressing to ensure it was intact, adhering in the affected area and change dressing as needed. During a review of Resident 25's Weekly Pressure Injury dated 10/30/24 indicated a Stage 1 in the coccyx measuring two centimeter (cm-unit of measurement) in length and two cm. in width. During a review of Resident 25's Pressure Sore Management Record dated 11/11/2024, the Pressure Sore Management Record indicated Stage II pressure injury on the coccyx measured two and half (2.5) cm. in length and two (2) cm. in width. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 25's COC Evaluation dated 11/11/2024, timed at 3:58 p.m., the COC indicated there was a small opening in the coccyx area where the redness was observed on 10/30/2024. During a review of Resident 25's Weekly Pressure Injury Skin Problem assessment dated [DATE], the Weekly Pressure Injury Skin Problem Assessment indicated the Stage II pressure injury was clarified and reclassified as left buttock from coccyx on 11/11/2024, measuring two and half (2.5) cm. in length and two (2) cm. in width by the physician. During a review of Resident 25's COC Evaluation, dated 11/19/2024, the COC indicated Wound Specialist physician observed a shearing on the sacral (bottom of the spine) area. During a review of Resident 25's Wound Assessment Report dated 11/19/2024, the Wound assessment Report indicated Stage II pressure injury on the sacrum. The Wound Assessment Report indicated shearing and described the wound as dry flaking epithelium (peeling skin) with hyperpigmentation (darkened area of skin discoloration that develops around the pressure wound). The Wound Assessment Report indicated to clean wound with soap and water, pat dry, apply zinc oxide paste (medicated paste that treats or prevents and protect skin from irritation) and dry foam dressing daily. During a review of Resident 25's Physician Order Summary Report dated 11/19/2024, the Order Summary Report indicated to cleanse pressure injury with normal saline (cleaning solution), pat dry, apply zinc oxide and cover with foam dressing daily for 14 days for Stage II on the left buttock. During a review of Resident 25's Physician Order Summary Report, the Physician Order Summary Report indicated the following orders: 1. On 11/11/2024, low air loss mattress with bolster for skin maintenance was ordered 2.On 11/21/2024, Prostat (liquid protein) 30 milliliters (ml- unit of measurement) daily protein supplementation. During a review of Resident 25's Weekly Pressure Injury dated 11/19/2024, the Weekly Pressure Injury indicated shearing and hyperpigmentation on the sacrum measuring 1.5 cm. in length and 1.5 cm. in width. During a concurrent interview and record review on 11/20/2024 at 4:11 p.m., with RN 4, reviewed Resident 25's electronic health record (EHR). RN 4 stated Resident 25 developed pressure injury due to poor food intake. RN 4 stated there was no added nutritional supplements or diet modification. RN 4 stated Resident 25 was not eating well and was refusing mechanical soft diet (diet of soft and moist food that are easy to swallow) so speech therapy consultation was ordered on 8/9/2024. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 11/21/2024, at 8:49 a.m., with Treatment Nurse (TN 1) in Resident 25's room, observed Resident 25 was tuned to her right side by Certified Nursing Assistant (CNA 3) and CNA 4. Observed dressing was absent on the left buttock and coccyx area where the Stage II pressure injury was located. Observed darkened skin discoloration, dry, flaky skin in the coccyx area and left buttock. TN 1 stated wound dressing was not in place because Resident 25 had a large bowel movement (process by which the body eliminate waste from the digestive tract) that occurred closed to breakfast and the dressing will be change by TN 1. TN 1 stated the charge nurse should have changed the wound dressing as needed if it gets soiled by urine and stool if the treatment nurse was not in the facility or unavailable. TN 1 stated the Stage II pressure injury was closed but not resolved per Wound Specialist Physician and remained a Stage II pressure injury. During an observation on 11/21/2024, at 9:45 a.m. during wound care dressing of Resident 25's pressure injury, observe Resident 25 was turned towards the left side of the bed by CNA 3 and CNA 4 after wound care dressing provided by TN 1. Observed a pillow positioned on the right upper side of resident's body and another pillow was placed on the left side on the upper body. Observed Resident 25's coccyx area was not offloaded because of the position of the two pillows on the right side and left side of her upper body. During a concurrent observation on 11/21/2024, at 12:00 p.m., and 1:30 p.m. Resident 25 was positioned on her back with pillows on both right and left side of the resident's body. During an interview on 11/20/2024, at 3:12 p.m. and subsequent interview on 11/21/2024, at 2:49 p.m. with CNA 3, CNA 3 stated Resident 25 was incontinent (inability to control the flow of urine or stool) of urine and stool. CNA3 stated Resident 25 does not wear an incontinence pad because of the type of mattress Resident 25 was using. CNA 3 stated they put a bath towel in between the legs and under the buttocks to help with the incontinence of stool or urine. During a concurrent interview and record review on 11/20/2024, at 4:35 p.m. and subsequent interview on 11/22/2024, at 12:43 p.m. with TN 1, reviewed Resident 25's EHR. TN 1 stated she found out Resident 25's pressure injury on the left buttock progressed to Stage 2 during her skin rounds on 11/11/2024. TN 1 stated the staff did not notify her about the progression of Resident 25's Stage 1 pressure injury to Stage 2 on the left buttock. TN 1 stated on 11/12/2024, wound specialist came and evaluated the Resident 25's wound and labeled the wound's location to be left buttock and not coccyx. TN 1 stated on 11/19/2024 wound specialist examined Resident 25's left buttock which showed shearing in the sacrum and change the treatment order to application of zinc oxide paste on the left buttock and sacrum then apply foam dressing. TN 1 stated Resident 25 was incontinent of stool and urine and the CNAs place bath towels right under and in between her legs to catch stool and urine as to not run down to the mattress. TN 1 stated Resident 25 needs to be repositioned every two hours to offload the left buttock and sacral area. TN 1 stated the facility used only pillow to turn and position resident and pointed out an observation made that the resident was positioned to left but the CNAs also placed a pillow on the right side of resident's body to turn resident to the left then placed a pillow on the right side of the body. TN 1 agreed Resident 25 was not properly repositioned and not offloading the sacrum and buttock when CNAs positioned Resident 25 on the back with pillows on both right and left side of the resident's body. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	TN 1 stated the facility should positioned resident properly to offload the buttock and sacrum. TN 1 stated CNAs should not use bath towels to catch urine or stool as it causes shearing to Resident 25 skin. TN 1 stated the bath towel are not designed to fit snugly around Resident 25's body like diapers, which can lead to increased friction and shearing when Resident 25 moves. TN1 does not absorb moisture effectively compared to diapers, prolonged exposure to moisture can lead to skin breakdown.TN 1 stated bath towels could cause skin breakdown because the texture of the material was rough. During an interview on 11/22/2024, at 3:03 p.m. with Director of Staff Development (DSD), DSD stated residents who are on low air loss mattress should use diapers and not bath towels for incontinence episodes because bath towels soaked with urine or stool that could lead to skin irritation and skin breakdown. DSD stated the resident (in general) should be turned every two hours and ideally residents should be provided incontinence or personal care every two hours. DSD stated the staff should not place pillow on both sides because the back was not being offloaded. DSD stated when Resident 25 was turned to the left, pillow should be placed on the right side of the resident's body, pillow under the legs for support and no pillow on the left side of the body to offload. During a concurrent interview and record review on 11/23/2024 at 2:51 p.m., with the Director of Nursing (DON), reviewed Resident 25's EHR. The DON stated all licensed staff and CNAs are responsible in monitoring the food intake of all residents. The DON stated if the resident was eating poorly the CNA should notify the charge nurses. The DON stated Resident 25 was eating poorly and confirmed there was no change of condition documented nor documentation the physician was notified about the weight loss on her EHR. The DON stated weight loss and pressure injury go together and Resident 25 was vulnerable to develop pressure injury because of Resident 25's poor food intake, immobility, incontinence of urine and stools and skin condition. The DON stated using of bath towels to prevent urine and stool to run down the air loss mattress should not be practiced because bath towel texture was rough and can cause skin breakdown. The DON stated using bath towels to absorb urine and stool and improper turning or positioning contributed to the development of Resident 25's pressure injury. During a review of facility's Position Description of a Treatment Nurse, the Position Description of a Treatment Nurse indicated The Treatment Nurse will provide primary skin care to residents under the medical direction and supervision of the resident's attending physician, the Director of Nursing Services, or the Medical Director of the facility, with an emphasis on the treatment and therapy of skin disorders. During a review of facility's policy and procedure (P&P) titled Skin Assessment revised 3/2023, the P&P indicated the licensed nurse completes routine monitoring of the resident's existing and potential risk factor for developing a pressure injury through the completion of a weekly assessment. The P&P indicated the sacrum and heels should be inspected and assessed for skin discoloration and pressure related concerns and are the areas of great vulnerability. The P&P indicated skin integrity should be assessed for pressure related discoloration or breakdown from positioning or use of medical devices.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45382 Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 2) were provided a resting hand splint (splint [rigid material or apparatus used to support and immobilize a broken bone or impaired joint] secured from the hand to the forearm to position the hand in a functional position) to Resident 2's left arm and a hand roll splint (splint placed in the palm of the hand used to position the hand in a functional position) to Resident 2's right hand in accordance with Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) recommendations on 6/28/2024. This failure had the potential to cause Resident 2 to have further range of motion (ROM, full movement potential of a joint) decline in both arms, contracture (loss of motion of a joint associated with stiffness and joint deformity) development, decreased mobility (ability to move) and a decline in activities of daily living (ADLs, basic activities such as eating, dressing, and hygiene). Findings: During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including right sided hemiplegia (weakness to the right side of the body) and hemiparesis (inability to move one side of the body) following a non-traumatic intracerebral hemorrhage (bleeding in the brain) and contractures (loss of motion of a joint associated with stiffness and joint deformity) of both hands and the lower leg. During a review of Resident 2's Physician Order Summary Report, the Physician Order Summary Report indicated a physician's order, dated 6/26/2024, for OT to evaluate Resident 2 to prevent further contractures of both hands. During a review of Resident 2's OT Evaluation and Plan of Treatment (OT Eval), initiated 6/26/2024, the OT eval indicated the reason for referral was due to a decline in ROM of Resident 2's both hands. The OT Eval indicated Resident 2 had impaired ROM in both shoulders and both hands and had rigid muscle tone (the amount of tension or resistance to movement in muscles) in both arms. The OT Eval indicated the OT recommended Resident 2 to wear a resting hand splint on the left hand and a hand roll on the right hand for four hours to maintain joint integrity and manage muscle tone. During a review of Resident 2's OT Discharge Summary, dated 6/28/2024, the OT Discharge Summary indicated Resident 2 was discharged from OT services due to transfer to Hospice care (care focused on comfort and quality of life of a person with a serious illness who is approaching the end of life). The OT Discharge Summary indicated the OT recommended Resident 2 to wear a resting hand splint on the left hand and a hand roll on the right hand for four hours on and four hours off (removed) to maintain joint integrity and manage muscle tone. The OT Discharge Summary indicated OT recommended an RNA program for splint or brace care and passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 10/2/2024, the MDS indicated Resident 2 had severely impaired cognitive (ability to think, understand, learn, and remember) skills for daily decision making. The MDS indicated Resident 2 was dependent in eating, hygiene, bathing, dressing, rolling to both sides, and transfers. The MDS indicated Resident 2 had functional limitations in ROM (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in both arms and both legs. During an observation on 11/19/2024 at 2:31 p.m., in Resident 2's room, Resident 2 was lying in bed with both elbows slightly bent with rolled up towels positioned in both hands. During a concurrent observation and interview on 11/21/2024 at 9:51 am, with Restorative Nursing Aide (RNA, nursing aide program that helps residents maintain their function and joint mobility) 1 in Resident 2's room, observed RNA 1session. Resident 2 was lying in bed with both elbows bent and both hands held in fists. RNA 1 provided PROM exercises to Resident 2's both shoulders, elbows, wrists, and hands for ten repetitions each at every joint (where two bones meet) at a very fast speed. Resident 2 bent both elbows and tightened both fists when RNA 1 tried to quickly straighten both elbows and all the fingers on both hands. Resident 2 moaned, grimaced, and appeared to be in pain during PROM exercises of both elbows and both hands. RNA 1 continuously told Resident 2 to relax and stop closing her hands so tightly during PROM exercises because it was hurting RNA 1's hands. After providing PROM to Resident 2's both arms, RNA 1 applied lotion to Resident'2 both hands and applied rolled up towels into the palm of Resident 2's hands. RNA 1 stated she worked with Resident 2 for a long time and never had orders to apply splints to both hands. RNA 1 stated she applied towel rolls to Resident 2 both hands to keep both hands open and to prevent the nails from digging into her palms because she always positioned her hands in fists. During a concurrent interview and record review on 11/21/2024 at 1:10 pm, the Director of Rehabilitation (DOR) who was the OT who evaluated Resident 2 reviewed Resident 2's OT therapy notes and confirmed OT recommended Resident 2 wear a left resting hand splint and a right-hand roll splint upon discharge from OT services on 6/28/2024. The DOR stated the physician referred OT to evaluate Resident 2 on 6/26/2024 for contracture management of both hands. The DOR stated Resident 2 did not have contractures of both hands but was at high risk for contracture development because she had increased muscle tone and always held both hands in a fists. The DOR stated he recommended a left resting hand splint and a right-hand roll splint because Resident 2 was at high risk for contracture development and could have benefitted from splinting. The DOR stated hand roll splints were not the same as the towel rolls placed in Resident 2's hands. The DOR stated the Rehabilitation Department was not involved in the placement of towel rolls in both hands since it was an intervention done by nursing. The DOR confirmed he recommended RNA for application of splints to Resident 2's both hands at the time of discharge from OT services but did not endorse the left-hand splint and right- hand roll to RNA for application since both hand splints were never issued to Resident 2. The DOR stated both splints were never issued to Resident 2 as recommended because he did not have time to assess Resident 2 for the appropriate splint wear time (length of time and frequency a person can tolerate wearing the splint for safety, comfort, and maximal benefits) since she was discharged from OT services so quickly. The DOR stated OT should have continued to follow up on the issuance and trialing of both hand splints because Resident 2 could have benefitted from both splints since she was at high risk for contracture development. The DOR stated if a resident needed a splint and did not receive it, it could potentially result in ROM decline and contracture development. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/22/2024 at 10:14 am, the Director of Nursing (DON) stated the Rehabilitation Department (Rehab) was responsible for assessment and issuance of splints to the residents in the facility. The DON stated it was important recommendations for splinting be carried out to prevent the residents from having a ROM decline and developing contractures. The DON stated if a resident needed a splint and did not receive it as recommended by Rehab, it could potentially result in a decline in ROM, overall function, and contracture development. During a review of the facility's undated OT Job Description, titled Registered OT Job responsibilities, the Job Description indicated the OT assured continuation of the therapy plan following discharge by designing and instructing patients, families, and caregivers in home exercises programs and recommending and/or providing assistive equipment. During a review of the facility's Policy and Procedure (P&P), titled Increase/Prevent Decline in ROM mobility, revised 3/2023, the P&P indicated the facility provided treatment and services to maintain or improve each resident's ROM and reduced further decline in ROM unless the resident's clinical condition demonstrated an unavoidable reduction in ROM. During a review of the facility's P&P, titled Splinting, revised 3/2023, the P&P indicated splints helped protect the skin from breaking down and contractures from becoming worse. The P&P indicated the therapist could assist in determining if a resident would benefit from splinting or other types of supportive care such as strengthening or positioning.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on observation, interview and record review, the facility failed to prevent the resident's unplanned weight loss of 9.2 percent (%) in three months and greater than 10 % in six months for one of two sampled residents (Resident 25). The facility failed to: a1 Ensure staff identified Resident 25's decrease oral intake (amount of food and water consumed), reassess, and monitor interventions to prevent a weight loss when Resident 25 had a weight loss of 15 pounds (lbs. unit of weight) from 5/7/2024 to 9/7/2024. 2. Ensure the nursing staff reported a decrease in Resident 25's oral intake to Resident 25's physician (MD1), in accordance with the Care Plan titled, Altered Nutrition/Hydration Status and Unplanned/ Unexpected weight loss of 4.8 percent (%) in one month on 9/7/2024, 9.2 % loss in three months and 10.5 % in six months on 11/11/2024. 3. Ensure licensed staff followed the facility's policy and procedure (P&P) titled, Nutrition (Impaired)/ Unplanned Weight Loss- Clinical Protocol and immediately notified physician of any abrupt or persistent change from Resident 25's food intake. These failures had the potential for Resident 25's continued weight loss and placed the resident at risk for malnutrition (lack of proper nutrition, caused by not eating enough), and dehydration (dangerous loss of body fluid). Findings: During a review of Resident 25's Admission Record, the Admission Record indicated Resident 25 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), paroxysmal atrial fibrillation (fast, irregular heartbeat that occurs suddenly and typically last for a short time), chronic kidney disease Stage III (kidneys are moderately damaged and are not filtering waste and fluid from the blood as it should be), pulmonary hypertension (condition that affects the blood vessels in the lungs that makes the heart work harder than normal to pump). On 7/14/2020 Resident 25 had a diagnosis of moderate protein -calorie malnutrition (state of inadequate intake of food- during resident stay in the facility). During a review of Resident 25's Minimum Dat Set (MDS- resident assessment tool) dated 11/2/2024, the MDS indicated Resident 25 had severe cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated Resident 25 was dependent (helper does all of the effort) on staff with bed mobility, bathing, toileting hygiene, personal hygiene, dressing, and transfer to and from the bed to chair. The MDS indicated Resident 25 weigh was 120 lbs. and height were 65 inches. The MDS indicated Resident 25 was not on a physician's prescribed weight loss regimen. During a review of Resident 25's Physician's Orders Summary Report from 1/28/2019 to 11/14/2024, the Physician's Orders Summary Report indicated the following orders: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. On 1/28/2019, Multivitamin with minerals to give one tablet by mouth one time a day for supplement. 2.On 1/28/2019, Vitamin C tablet 500 milligram (mg- unit of measurement) to give one tablet by mouth one time a day for supplement. 3.On 2/6/2024, Glucerna (replacement shake to help manage blood sugar with people with diabetes) 80 milliliters (ml- unit of measurement) three times a day. 4.On 5/10/2024, Remeron (medicine used to treat depression and can increase appetite) 15 mg to give one tablet by mouth at bedtime for depression manifested by poor oral intake. 5. On 8/9/2024, Regular Pureed (food that had been mashed, ground, crushed until it is smooth and has the consistency of a creamy paste) texture diet, thin liquid consistency, eight ounces super milk (type of milk that is higher in protein and fat than regular milk) three times a day with meals; four ounces (oz-unit of measurement) of prune juice at breakfast, super cereal (fortified wheat, soy, milk that is processed and packed). 6. On 11/14/2024, Remeron was decreased to 7.5 mg to give one tablet by mouth at bedtime for depression as manifested by poor oral intake. During a review of Resident 25's care plan titled Altered Nutrition/Hydration Status initiated on 5/18/2024 and revised on 8/8/2024 the care plan indicated the goal for Resident 25 was to consume 68 percent (%) of meal served daily and to have no significant weight loss through review date of 1/31/2025. The Care plan interventions included to monitor Resident 25 weight at every month or as ordered, provide 4.0 oz of prune juice at breakfast, 8.0oz whole milk with meals, fortified (foods with nutrients added to them) cereal at breakfast, provide nutritional supplements, peanut butter and jelly with lunch and dinner, and notify the physician and Registered Dietician (RD) of significant weight loss/ gain. During a review of Resident 25's Care Plan titled, Unplanned/ Unexpected weight loss on 9/7/2024 of 4.8 % in one month, 9.2 % weight loss in three months and 10.5 % weight loss in six months, initiated on 9/10/2024 and revised on 11/12/2024, the Care Plan indicated the goal for Resident 25 was not to have further weight loss through review date and the resident will consume at least 75 % of meal served daily. The Care plan interventions included to monitor and evaluate any weight loss, assist with feeding as needed, if weight decline persists contact physician and dietician immediately. During a review of Resident 25's Care Plan titled, Unplanned/ Unexpected Weight loss related to poor food intake, the Care Plan indicated the resident had a weight lost as follows: 1. On 2/5/2024 3 % weight loss for one week, 2. On 2/13/2024 3.8 % weight loss for one week, 3.6 % weight loss for one month, (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 7/7/2024 3.8 % weight loss for one month (5/7/2024-7/8/2024 eight pounds) initiated on 2/6/2024 and revised on 8/8/2024. The Care plan goal was for Resident 25 to consume at least 50 % of meal served daily and not to have a further weight loss through review date. The Care Plan interventions included to monitor oral intake every meal, to document in the Medication Administration Record (MAR) a one (1) if less than 50 % of food consumed and document zero (0) if greater than 50 % was consumed, to administer Remeron 15 mg at bedtime for depression as manifested by poor oral intake, and monitor weight loss and if the weight decline persists to contact the physician and ensure dietitian was aware. During a review of Resident 25's RD's Nutritional Update notes dated 5/1/2024, the Nutritional Update notes indicated there was no significant Resident 25's weight changes and Resident 25's food intake was 50 to 75 %. The RD Nutritional Update note indicated there was no new diet order and to continue mechanical soft diet with thin liquid consistency, super cereal with breakfast, 8.0 oz of fortified milk. During a review of Resident 25's RD's Nutritional Update notes dated 8/13/2024, the Nutritional Update notes indicated resident's average meal percentage intake was 15 % in one week and the resident weight was 122 lbs. The Nutritional Update note indicated the resident's weight loss was related to poor food intake; IDT was following and would continue to monitor weights weekly until stable. During a review of Resident 25's RD Nutritional Update note dated 11/5/2024, the Nutritional Update note indicated Resident 25 had a body mass index (BMI- a measure that relates body weight to height) of 20 (under range for age), with a most recent weight of 120 lbs. and had 9.7 % weight loss in 6 months (5/7/2024- 11/8/2024). The RD's Nutritional Update note indicated the Resident 25's average meal percentage intake was 10 to 20 %. The Nutritional Update note indicated to continue plan of care. During a review of Resident 25's Weight Variance Team Update notes dated 11/12/2024, the Weight Variance Team Update notes indicated Resident 25 had 10.5 % weight loss in 6 months (dates not indicated). The Weight Variance Team Update note indicated IDT's recommendation were to request Pre-Albumin level (blood test that can indicate malnutrition), Zinc Sulfate (supplement used to help with wound healing) daily for three weeks and current nutritional supplements remained appropriate. During a review of Resident 25's Weights and Vitals Summary from 5/7/2024 to 11/8/2024, the Weights and Vitals Summary indicated Resident 25's weight was as follows: 1. 5/7/2024- 133 lbs. 2. 6/10/2024- 130 lbs. 3. 7/8/2024- 125 lbs. 4. 7/15/2024- 125 lbs. 5. 7/22/2024-123 lbs. 6. 7/29/2024-124 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. 8/6/2024 -124 lbs. (nine lbs. weight loss within 3 months [6.77 %] weight loss from 5/7/24 to 8/6/24) 8. 8/7/2024 -124 lbs. 9. 8/12/2024 -122 lbs. 10. 8/20/2024 -122 lbs. 11. 9/7/2024- 118 lbs. 12. 10/8/2024-120 lbs. 13. 11/8/2024 -119 lbs. (14 lbs. weight lost in 6 months [10.53 %] weight loss from 5/7/24 to 11/8/24). During a review of Resident 25's Documentation Survey Report for Nutrition (Meal Percentage) from 9/1/2024 to 11/20/2024 the Documentation Survey Report indicated Resident 25's consumed meal percentage varied from 0% to 14 %, and from 40 to 50 %. During a concurrent observation and review on 11/20/2024, at 12:57 p.m., in Resident 25's room, Resident 25's lunch meal was observed. Resident 25 drank all the liquids provided for lunch but only ate small number of pureed potatoes. A Review of Resident 25's meal ticket indicated Resident 25 was on Control Carbohydrates Diet (CCD), puree texture, thin liquid consistency with no added salt. Resident 25's food likes were peanut butter and jelly (PBJ) sandwich and dislikes spinach, and pureed meal consistency Resident 25 lunch tray was observed to have pureed greens, pureed meat, and pureed potatoes. During an interview on 11/20/2024, at 1:15 p.m., and subsequent interview on 11/20/2024, at 3:12 p.m. Certified Nursing Assistant (CNA 3) stated he fed Resident 25 who consumed the milk, juice, few bites of pureed potatoes and peanut butter and jelly sandwich. CNA 3 stated Resident 25 was on pureed diet with a peanut butter and jelly sandwich, and her meal intake varied. CNA 3 stated today (11/20/2024) Resident 25 ate 20 % for breakfast and 50 % for lunch which included the peanut butter and jelly sandwich. CNA 3 stated charge nurse should be notified if a resident food intake was only 20 %. CNA 3 stated yesterday (11/19/2024) Resident 25's food intake was 15 % and he did not notify the charge nurse. During an interview on 11/20/2024, at 3:29 p.m. Licensed Vocational Nurse (LVN2) stated she was aware that Resident 25 was eating poorly and was on regular diet with puree texture and thin liquid consistencies. LVN 2 stated Resident 25 used to be on mechanical soft diet. LVN 2 stated Resident 25 was on Remeron since May 2024 for appetite stimulant (medication that increases feelings of hunger) but continued to eat poorly. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/2024, at 3:56 p.m. with Registered Nurse Supervisor (RN 3) stated Resident 25 had a weight loss greater than three lbs. from 5/7/2024 to 8/7/2024 (6.7 % weight loss) and had lost 14 lbs. within 6 months (5/7/2024 to 11/8/2024, which was a significant weight loss). RN 3 stated Resident 25's physician was not notified of the significant weight loss until 11/13/2024 and recommended hospice care (compassionate care for people who are near the end of life). RN 3 stated the facility failed to monitored food intake and notify MD1 of Resident 25 progressive significant weight loss. During a review of Resident 25's Nurses Progress Notes dated 11/13/2024, timed at 11:03 a.m. the Nurses Progress Notes indicated the Director of Nursing (DON) sent a message to Resident 25's physician through text to inform of Resident 25's significant weight loss. During a concurrent interview and record review on 11/21/2024, at 12:52 p.m. with Dietary Supervisor (DS Resident 25's electronic health record (EHR) was reviewed. The DS stated Resident 25 was part of Weight Variance Committee meeting and the Committee met weekly. The DS stated Resident 25 was receiving eight ounces of super milk, super cereal for breakfast and ice cream for dinner which was ordered on 8/9/2024 for weight loss. The DS stated Resident 25 was also receiving Glucerna 80 ml three times a day since February 2024. The DS stated Resident 25 continued to lose weight despite interventions. The DS stated if the calories were not enough to cover the nutritional needs of Resident 25, current interventions for weight loss should be evaluated because weight loss could get worse. During a concurrent telephone interview and record review on 11/22/2024, at 3:44 p.m. with RD Resident 25's HER was reviewed. The RD stated Resident 25 started to lose weight on 9/7/2024 and lost 12 lbs. in three months. RD stated she did not know why Resident 25 continue to lose weight with interventions in place. The RD stated the Interdisciplinary Team (IDT- group of professional and direct care staff that have primary responsibility for the development of a plan for the care of a resident) reached out to the resident and family. The RD stated she never saw Resident 25 to assess the resident and observe the resident's food intake. The RD stated Resident 25 was confused, does not communicate well so RD rely mostly on staff to talk to Resident 25. The RD stated her recommendations for weight loss would be to fortify (adding nutrients to a food that are not naturally present in it) foods and update resident's preferences. The RD stated if the resident continues to lose weight interventions should be reassessed and modify. During a concurrent interview and record review on 11/23/2024, at 12:43 p.m. RN 4 stated Resident 25 weight loss was observed on 9/7/2024 when Resident 25 weight dropped to 118 lbs. RN 4 stated on 11/12/2024 the RD recommended to check Pre-Albumin level and Zinc Sulfate 220 mg one tablet a day for three weeks. Reviewed Resident 25' Pre-Albumin laboratory result, RN 4 stated Resident 25's Pre-Albumin level was 13 (Normal Pre-Albumin level 16-30 milligrams (mg- unit of measurement) per deciliter (dL-) or 160-300 milligrams per liter (mg/L) Pre-Albumin 13 mg/dl is considered low and could indicate potential malnutrition). RN 4 stated Resident 25's meal intakes had been poor because resident only liked milk and PBJ sandwich. After reviewing Resident 25's EHR, RN 4 stated no COC or notification of physician was documented for the resident's significant weight loss identified on 9/7/2024. RN 4 reviewed Resident 25's Nurses Progress Notes from 11/13/2024 to 11/19/2024 and stated the Nurses Progress Notes indicated there was no follow up call to Resident 25's physician about his significant weight loss. RN 4 stated Resident 25's weight loss could be preventable if interventions to prevent further weight loss were reviewed, modify and physician notified in a timely manner. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/23/2024, at 2:51 p.m. with the DON Resident 25's EHR was reviewed. The DON stated there was no documentation indicating that COC was completed, a change in a diet or dietary interventions to prevent a weight loss were attempted and that the physician was notified of the of Resident 25's significant weight loss. The DON stated weight loss was a change in condition and physician should have been notified. The DON stated all licensed nurses were responsible in monitoring Resident 25's food intake. During a review of facility's policy and procedure (P&P) titled Assisted Nutrition and Hydration, revised March 2023, the P&P indicated the facility assist the resident to maintain, to the extent possible, acceptable parameters of nutritional and hydration status. The P&P indicated the facility will recognize, evaluate, and address the need of every resident, including but not limited to, the resident at risk or already experiencing impaired nutrition and hydration. During a review of facility's P&P titled Notification of Change, revised 3/2023, the P&P indicated the facility informs the resident, resident's physician and the resident's representative when there is a significant change in resident's physical, mental or psychosocial status, deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications or a need to change treatment significantly or to start a new form of treatment.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45382 Based on observation, interview, and record review, the facility failed to ensure: a. Ensure Restorative Nursing Aides (RNA- trained nursing staff who help residents gain an improved quality of life by increasing their level of strength and mobility) 1 was competent to perform passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises to Resident 2's both arms. b. Ensure RNA 1 was competent to perform PROM exercises to Resident 18's right arm. These failures had the potential to cause resident pain, harm, injury, and inefficient delivery of ROM exercises resulting in decreased the range of motion and function for residents receiving RNA services. c. Performance Evaluation was completed on Registered Nurse (RN)4 and Licensed Vocational Nurse according to facility's policy and procedure. This failure had the potential for the facility not be able to assess the skills necessary to provide nursing services to assure resident safety. Findings: a. During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including right sided hemiplegia (weakness to the right side of the body) and hemiparesis (inability to move one side of the body) following a non-traumatic intracerebral hemorrhage (bleeding in the brain) and contractures (loss of motion of a joint associated with stiffness and joint deformity) of both hands and the lower leg. During a review of Resident 2's Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) Evaluation and Plan of Treatment (OT Eval), dated 6/26/2024, the OT Eval indicated Resident 2 had impaired ROM on both arms and had rigid muscle tone (the amount of tension [resistance to movement] in muscles) with a muscle tone severity of two (slight increase in muscle tone with minimal resistance). During a review of Resident 2's Physician Order Summary Report, the Physician Order Summary Report indicated a physician's order, dated 9/11/2024, for RNA to perform PROM exercises to Resident 2's both arms, five times a week. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 10/2/2024, the MDS indicated Resident 2 had severely impaired cognitive (ability to think, understand, learn, and remember) skills for daily decision making. The MDS indicated Resident 2 was dependent in eating, hygiene, bathing, dressing, rolling to both sides, and transfers. The MDS indicated Resident 2 had functional limitations in ROM (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in both arms and both legs. During an observation of an RNA session on 11/21/2024 at 9:51 a.m., in Resident 2's room, Resident 2 was lying in bed with both elbows bent and both hands held in fists. RNA 1 provided PROM exercises to Resident 2's both shoulders, elbows, wrists, and hands for ten repetitions each at every joint (where two bones meet) at a very fast speed. Resident 2 bent both elbows and tightened both fists when RNA 1 tried to quickly straighten both elbows and all the fingers on both hands. Resident 2 moaned, grimaced, and appeared to be in pain during PROM exercises of both elbows and both hands. RNA 1 continuously told Resident 2 to relax and stop closing her hands so tightly during PROM exercises because it was hurting RNA 1's hands. During an interview on 11/21/2024 at 1:06 p.m., RNA 1 stated she provided PROM exercises to Resident 2's arms and hands at a very fast rate of speed. RNA 1 stated she noticed Resident 2's arms and hands became tighter and harder for her to move and straighten when she was doing PROM exercises quickly. RNA 1 stated Resident 2 had pain during PROM exercises because she noticed Resident 2 became more resistive to the exercises as the session progressed, moaned, grimaced, and needed a lot of rest breaks in between exercises. During a concurrent interview and record review on 11/21/2024 at 1:10 p.m., the Director of Rehabilitation (DOR) who was also an OT stated Resident 2 had hypertonicity (condition where the muscles are in a constant state of contraction or increased tension usually due to neurological issues, injury, or certain medical conditions) in both arms and always held both hands in a fist. The DOR reviewed Resident 2's OT Eval, dated 6/26/2024, and confirmed Resident 2 had hypertonicity in both arms. The DOR stated ROM exercises must be done slowly for any resident with hypertonicity because providing ROM at a fast pace could cause the muscles of the arm to bend more instead of straightening which could cause pain. b. a. During a review of Resident 18's Admission Record, the Admission Record Resident 18 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including right sided hemiplegia hemiparesis following a cerebral infarction (blockage of the flow of blood brain, causing or resulting in brain tissue death), muscle weakness, and aphasia (loss of ability to understand or express speech, caused by brain damage). During a review of Resident 18's OT Eval, dated 1/18/2024, the OT Eval indicated Resident 18 had impaired ROM of the right arm and had rigid muscle tone in the right arm. During a review of Resident 18's Order Summary Report, the Order Summary Report indicated a physician orders, dated 3/12/2024, for RNA to perform PROM exercises to Resident 18's right arm, five times a week. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 18's MDS, dated [DATE], the MDS indicated Resident 18 was cognitively intact. The MDS indicated Resident 18 required set-up assistance for eating, required partial/moderate assistance for upper body dressing and personal hygiene, and required substantial/maximal assistance for toileting hygiene, bathing, and lower body dressing. The MDS indicated Resident 18 had functional limitations in ROM in one arm and one leg. During an observation of an RNA session on 11/21/2024 at 9:23 am, in Resident 18's room, Resident 18 was sitting in a wheelchair watching television. RNA 1 assisted Resident 18 with sit to stand exercises in the hallway, RNA 1 assisted Resident 18 with PROM of the right arm. RNA 1 provided Resident 18 with right arm shoulder, elbow, wrist, and hand PROM exercises for ten repetitions each at every joint at a very fast speed. Resident 18's right elbow, wrist, and fingers were observed to bend more while RNA was trying to quickly straighten each joint. Resident 18 grimaced, stated he had pain during PROM exercises, and asked RNA to stop. During an interview on 11/21/2024 at 1:06 pm, RNA 1 stated she provided PROM exercises to Resident 18's right arm and hand at a very fast rate of speed. RNA 1 stated she noticed Resident 18's right arm and hand became tighter and harder to move and straighten when she was doing PROM exercises quickly. RNA 1 stated Resident 18 had pain during PROM exercises because she noticed Resident 18 became more resistive to the exercises as the session progressed, moaned, grimaced, and had difficulty tolerating a lot of ROM exercises. During a concurrent interview and record review on 11/21/2024 at 1:10 p.m., the DOR who was also an OT reviewed Resident 18's OT Eval, dated 1/18/2024, and confirmed Resident 18 had hypertonicity in the right arm. The DOR stated ROM exercises must be done slowly for any resident with hypertonicity because providing ROM at a fast pace could cause the muscles of the arm to bend more instead of straightening which could cause pain. During a concurrent interview and record review on 11/22/2024 at 9:54 a.m., the DSD stated the RNAs in the facility were CNAs specialized training in RNA services. The DSD stated she was responsible for completing CNA competencies yearly but never completed any competencies for the RNAs. The DSD stated she did not know who was responsible for completing RNA competencies in the facility and did not know if they were being done. The DSD stated the CNA competency checklist did not assess staff's competency of RNA tasks such as ROM exercises, splinting, and ambulation exercises. The DSD stated it was important for the facility to have recurring competency assessments for staff to ensure the care and services provided were appropriate and safe. The DSD stated it placed the residents in the facility at risk for harm if staff were not competent in the services they were providing. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/22/2024 at 10:14 am, the DON and ADM stated conducting staff competencies were important to ensure staff were up to date and competent in performing their job duties. The DON stated there were three RNAs in the facility. The DON stated the RNAs assisted residents with activities such as ROM exercises, ambulation exercises, splinting, and feeding to ensure the residents in the facility maintained their current level of function and did not experience a functional decline. The DON and ADM stated the facility did not have a way to ensure the RNA staff were competent in their job duties since they did not conduct RNA competencies. The DON stated a licensed therapist from the contracted rehabilitation department provided the initial RNA certification but did not return to provide any additional training or competencies after the initial RNA certification was issued. The DON and ADM stated competencies for all staff should be done annually to ensure staff were competent in the services provided but were not being done for the RNAs. The DON and ADM stated if RNA competencies were not completed at least annually, the facility would not know the staff were up to date and competent in their job duties which could potentially lead to injury of staff and/or residents. During a review of the facility's policy and procedures (P&P), titled, Nursing Services, revised 3/2023, the P&P indicated the facility had sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychological well-being of each resident. 45269 c.During a concurrent interview and record review on 11/23/2024, at 9:19 a.m., with Director of Staff Development (DSD), reviewed Certified Nursing Assistant (CNA 5) employment file. DSD stated CNA 5 Performance Review was not on file and was missing. DSD stated Performance Evaluation of any staff should be conducted annually and after 90 days from hire if a staff is a newly hired. During a concurrent interview and record review on 11/23/2024, at 9:19 a.m., with DSD, reviewed Licensed Vocational Nurse (LVN 2) employment file, DSD stated LVN 2 had no annual performance evaluation on file. DSD stated the Director of Nursing (DON) oversees performance evaluations of licensed nurses. During an interview on 11/23/2024, at 12:38 p.m. with Registered Nurse (RN 4), RN 2 stated he just had his performance review a few days ago. RN 4 stated all staff should be evaluated for their performance annually. RN 4 stated it was important to have your performance evaluated to know your weaknesses and strength which was important in providing quality of care to the residents. During an interview on 11/23/2024, at 2:51 p.m. with Director of Nursing (DON), the DON stated LVN 2 did not have her Performance Evaluation on file. The DON stated the facility conducts an annual Performance Evaluation to ensure staff competency because they are dealing with residents and to ensure safe delivery of care. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's policy and procedure (P&P) titled 'Performance Evaluation dated 3/2024, the P&P indicated Job performance of each employee must be reviewed and evaluated per company guidelines and in accordance with State and Federal regulatory requirements. The P&P indicated performance evaluations are conducted to evaluate the employee's work performance and to be used as a tool for determination of employee eligibility for promotion, disciplinary actions and education, terminations, shift changes, transfers, improvement of quality and overall review of the employees 'work performance. The P&P indicated the employee's immediate supervisor or designee will be responsible for completing performance evaluation.

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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** 31333 Based on interview and record review the facility failed to accurately account for the use of controlled substances (medications with a high potential for abuse) for three out of four sampled residents (Resident 31, Resident 46, and Resident 12) reviewed. 1. Resident 31, the facility failed to accurately account for the administration of a lorazepam 0.5 milligrams ([mg-unit of measurement] a controlled substances used to relieve anxiety, a mental disorder characterized by persistent feelings of worry, nervousness, or unease strong enough to interfere with daily activities) on 10/5/2024 and 10/6/2024. 2. Resident 46, the facility failed to accurately account for the administration of tramadol (a controlled substances used to treat moderate to severe pain) 50 mg on 10/5/2024. 3. Resident 12, the facility failed to accurately account for the administration of tramadol 50 mg on 10/2/2024. These failures increased the risk that controlled medications to treat pain and anxiety may not be administered as ordered for Resident 31, Resident 46, and Resident 12 with the potential for the residents to experience uncontrolled pain, discomfort, or anxiety. And the facility's risk for the potential loss, diversion (transfer of a medication from a legal to an illegal use), medication errors, or accidental exposure to controlled substances. Findings: 1. During a review of Resident 31 ' s Admission Record, the Admission Record indicated Resident 31 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnosis including anxiety (a feeling of fear, dread, and uneasiness that can be a normal reaction to stress) disorder. During a review of Resident 31's History and Physical (H&P), dated 11/8/2024, the H&P indicated Resident 31 does not have the capacity to make decisions and dependent on facility staff for all Activities of Daily Living (ADL, include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating). During a review of Resident 31's Physician Order Summary Report, included an order for lorazepam 0.5 mg, instructions to give one tablet by mouth every four hours as needed for anxiety as manifested by fidgeting (small movements), order date 10/3/2024. During a concurrent interview and record review on 11/21/2024 at 11:27 a.m., with Licensed Vocational Nurse (LVN) 3 and Director of Nursing (DON) on Station 2, at Medication Cart (Med Cart) 2, reviewed Resident 31's Medication Administration Record (MAR) and Controlled Drug Record (CDR, a complete and accurate record to help maintain inventories to avoid diversions and losses) and the following discrepancy was found between the CDR and the MAR for Resident 31: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 31's CDR indicated licensed nurse initialed the removal of two tablets of lorazepam 0.5 mg on 10/5/2024 at 9 p.m., and again on 10/6/2024 at 9 p.m. Resident 31 ' s MAR for the month of 10/2024 was missing licensed nurse's initials to indicate Resident 31 was administered two doses of lorazepam 0.5 mg on 10/5/2024 and 10/6/2024 at 9 p.m. on each of the two days. During a concurrent interview on 11/21/2024 at 11:27 a.m. with LVN 3 and the DON, LVN 3 stated, the licensed nurses signed for the lorazepam removal in the CDR but did not click on the MAR to document the administration of lorazepam 0.5 mg to Resident 31 on 10/5/2024 at 9 p.m. and 10/6/2024 at 9 p.m. The DON stated, the lorazepam used as needed for Resident 31 was not documented on as administered, on the MAR. 2. During a review of Resident 46's Admission record, the Admission Record indicated Resident 46 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and osteomyelitis (inflammation of bone, usually due to infection). During a review of Resident 46's Minimum Data Set (MDS - a resident assessment tool), dated 9/19/2024, the MDS indicated Resident 46 was able to understand and be understood by others. The MDS indicated Resident 46 required setup or clean up assistance for eating and oral hygiene and partial assistance (helper performs less than half of the effort) for toileting and dressing. During a review of Resident 46's Physician Order Summary Report, included an order for tramadol 50 mg, instructions indicated to give one tablet by mouth every 24 hours as needed for moderate to severe pain (pain rating 4 to 10), order date 9/12/2024. During a review of Resident 46 ' s Care Plan titled Resident 46 at risk for pain and discomfort dated 9/13/2024, indicated, interventions to administer analgesic as ordered. Encourage rest period to facilitate relief. Re-check for efficacy at least 30 minutes after administration. If symptoms persist, notify physician (MD). During a concurrent interview and record review on 11/21/2024 at 11:30 a.m., with LVN 3, Resident 46's MAR and CDR for the month of 10/2024 was reviewed. The following discrepancy was found between the CDR and the MAR for Resident 46, Resident 46's CDR indicated licensed nurse initialed the removal of tramadol 50 mg on 10/5/2024 at 10:10 p.m., but Resident 46's MAR was missing a licensed nurse's initials to indicate the administration of the medication on 10/5/2024. LVN 3 stated, if the administration of the medication was not documented on the resident's MAR, the licensed nurses would not know if the resident was administered the medication. LVN 3 stated the licensed nurse must document on the MAR and on the CDR, both records must match and that did not happen for Resident 46. 3. During a review of Resident 12's Admission Record, the Admission Record indicated Resident 12 was admitted to the facility on [DATE], with diagnosis of wedge compression fracture of second lumbar vertebra (a type of spinal fracture that occurs when the front of the vertebra collapses, giving the bone a wedge shape). During a review of Resident 12's MDS dated [DATE], indicated the resident had severe cognitive (ability to think, understand, learn, and remember) impairment. (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 12's Physician Order Summary Report, included an order for tramadol 50 mg, instructions indicated to give one tablet by mouth every eight hours as needed for moderate pain (pain rating 4 to 6), order date 9/21/2024. During a review of Resident 12 ' s Care Plan titled Resident 12 at risk for pain and discomfort dated 9/23/2024, indicated, interventions to administer analgesic as ordered. Encourage rest period to facilitate relief. Re-check for efficacy at least 30 minutes after administration. If symptoms persist, notify physician (MD). During a concurrent interview and record review on 11/21/2024 at 11:30 a.m., Med Cart 3, with LVN 2, Resident 12's MAR and CDR for the month of 10/2024 was reviewed. The following discrepancy was found between the CDR and the MAR for Resident 12, Resident 12's CDR indicated licensed nurse initialed the removal of tramadol 50 mg on 10/2/2024 at 11 a.m., but Resident 12's MAR was missing a licensed nurse's initials to indicate the administration of tramadol 50 mg on 10/2/2024. LVN 2 stated Resident 12's tramadol should have been documented on both the MAR and CDR to indicate the medication was administered. LVN 2 stated the discrepancy could lead to another nurse administering the tramadol again to Resident 12, or if the resident was not administered the medication could cause the resident to experience more pain. LVN 2 stated diversion of the medication could occur if the tramadol was popped out and not administered to the resident. During an interview on 10/21/2024 at 12:35 p.m., with a Registered Nurse Supervisor (RN) 4, RN 4 stated the CDR and MAR documentation for medication administration should match, if not it may indicate the medication was not given to the resident. RN 4 stated if the controlled medications, lorazepam, and tramadol was not documented as administered to the residents (Resident 31, Resident 46, and Resident 12) it could lead to drug (medication) diversion; residents experiencing pain or anxiety if the medications were not administered, or the residents could receive duplicate therapy if the medication is mistakenly administered again. During an interview on 10/21/2024 at 1:21 p.m., with the Registered Nurse Consultant (RNC), RNC stated the licensed nurse must during medication pass follow the steps of pour, pass, and chart any medication given to the resident on the MAR and for controlled medication, must document on the CDR. RNC stated if not documented it was not considered done. During a review of the facility's policy and procedures (P&P) titled, General Dose Preparation and Medication Administration, revised, 1/2013, indicated, Prior to administration of medication .Confirm that the MAR reflects the most recent medication order .During the medication administration .Document the administration of controlled substances in accordance with applicable law .After medication administration, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: Document necessary medication administration/treatment information (e.g., when medications are opened, when medications are given .) on appropriate forms.

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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** 31333 Based on observation, interview and record review, the facility failed to ensure it was free of medication error rate of five percent (%) or greater as evidenced by four medication errors out of 27 opportunities for error to yield a medication error rate of 14.81 %, for three of five residents (Residents 29, Resident 48, and Resident 42) observed during medication administration (med pass). The facility failed to ensure: 1. Resident 29's blood pressure ([BP] the force of blood against artery [blood vessel that carries blood away from the heart] walls as the heart pumps) and/or heart rate/pulse ([HR] the number of times the heart beats per minute [bpm]) was accurately assessed as a parameter ordered by the physician to determine whether to hold or administer resident's BP medication, amlodipine 2.5 milligrams (mg, unit of mass) 2a. Resident 48's BP and/or HR was accurately assessed as a parameter ordered by the physician to determine whether to hold or administer resident's BP medication, amlodipine 10 mg. 2b. Resident 48's ClearLax (also known as MiraLAX [polyethylene glycol 3350 powder, for solution] used to treat occasional constipation) was prepared in accordance with the physician's order and manufacturer's specification. 3. Resident 42 was administered metformin (a medication that treats type 2 diabetes [a long-term condition in which the body has trouble controlling blood sugar and using it for energy] 1000 mg, with food or a meal as order by the physician. These failures of medication administration error rate of 14.81 % exceed the five (5) percent threshold. Findings: 1. During a review of Resident 29's Admission Record, the Admission record indicated Resident 29 was admitted to the facility on [DATE] with diagnoses including hypertension (high blood pressure) and fall on same level from slipping, tripping, and stumbling. During a review of Resident 29's Minimum Data Set (MDS, a resident assessment tool) dated 10/12/2024, the MDS indicated Resident 29's cognitive (ability to think, understand, learn, and remember) skills for daily decisions making was severely impaired. (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 29's Care Plan titled, At risk for altered level of comfort/pain; At risk for weakness or activity intolerance due to alteration in cardiovascular (relating to the heart and blood vessels) function r/t (related to) HTN (hypertension - high blood pressure). The care plan interventions included, amlodipine besylate (treat high blood pressure) oral tablet, give one tablet by mouth one time a day for hypertension. Hold for systolic blood pressure ([SBP] pressure in the arteries when the heart beats) less than 110 millimeters of mercury (mmHg) or heart rate less than 55 bpm, date initiated 3/22/2023 . Administer medication as ordered; monitor side effects and effectiveness and notify MD if ineffective or for any indication of side effects .monitor BP as needed, monitor pulse (heart rate) as needed . During a review of Resident 29's Physician Order Summary Report, included an order for amlodipine 2.5 mg, instructions to give one tablet by mouth one time a day for hypertension. Hold for SBP less than 110 mmHg or HR less than 55 bpm, order date 7/6/2023. During a Medication Pass observation on 11/20/2024 at 10:14 a.m., at Station 2 Medication Cart (MedCart) 2 with Licensed Vocational Nurse (LVN) 1, LVN 1 prepared and administered to Resident 29 four medications which included a BP medication, amlodipine without checking the resident's BP as a parameter ordered by the physician to determine when to administer or not administer the resident's BP medication. LVN 1 prepared and administered the following medications to Resident 29: 1. Amlodipine 2.5 mg, one tablet 2. Aspirin (prevention of cerebrovascular accident [CVA] a stroke, caused by interrupted blood flow to the brain) 81 mg, one tablet 3. Docusate Sodium (stool softener) 100 mg, one capsule 4. Multivitamin with Minerals (supplement), one tablet During an interview on 11/20/2024 at 11:06 a.m., with LVN 1, LVN 1 stated he was supposed to check resident's BP right before administering the BP medication when there is a parameter to indicated when to administer or hold the BP medication. LVN 1 stated resident's (Resident 29) BP could change or drop, which could lead to the resident experiencing a fall or injury. 2. During a review of Resident 48's Admission Record, the Admission Record indicated Resident 48 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hypertension, orthostatic hypotension (a drop in blood pressure when standing up from sitting or lying down, causing dizziness), difficulty walking, ulcerative colitis (a chronic, inflammatory bowel disease that causes inflammation in the digestive tract), and diverticulitis (inflammation that causing pain and disturbance of bowel function). During a review of Resident 48's MDS, dated [DATE], the MDS indicated Resident 48's cognitive skills for daily decisions making was severely impaired. (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 48's care plan title At risk for altered level of comfort/pain; At risk for weakness or activity intolerance due to alteration in cardiovascular function related to HTN, orthostatic hypotension, and hypokalemia (low potassium level) initiated on 7/27/2023. Resident 48's care plan interventions included, amlodipine besylate 10 mg, give one tablet by mouth one time a day for HTN. Hold for SBP less than 110 mmHg or HR less than 55 bpm .monitor BP as needed, monitor pulse (HR - heart rate) as needed. During a review of Resident 48's care plan titled Has altered gastrointestinal (GI - stomach) status, at risk for: GI discomfort, decreased food intake, irregular bowel elimination, and signs and symptoms of constipations initiated on 7/27/2023. Resident 48's care plan interventions included, administer medications as ordered to facilitate relief of GI symptoms. Notify MD if ineffective .MiraLAX (used to treat occasional constipation) Powder (polyethylene glycol 3350), give 17 grams (gm, unit of mass), one time a day for constipation. Mix with 4 (four) to 8 (eight) ounces ([oz] - a unit of measure for volume) of water. Monitor for GI symptoms (i.e., abdominal pain, nausea, vomiting, diarrhea, constipation, blood in stool) and notify MD if present. During a review of Resident 48's Order Summary Report, included orders for: Amlodipine 10 mg, instructions indicated to give one tablet by mouth one time a day for HTN. Hold for SBP less than 110 mmHg or HR less than 55 bpm, order date 6/23/2023. MiraLAX Powder, instructions indicated to give 17 gm by mouth one time a day for constipation, mix with 4-8 oz of water, order date 6/23/2023 During a Medication Pass observation on 11/20/2024 at 10:30 a.m., on Station 2 at MedCart 2 with LVN 1, LVN 1 prepared and administered to Resident 48 six medications which included a BP medication, amlodipine without checking the resident's BP as a parameter ordered by the physician to determine when to administer or not administer the resident's BP medication. LVN 1 prepared the following medications for Resident 48: 1. Amlodipine 10 mg, one tablet 2. Vitamin C (supplement) 500 mg, one tablet 3. Docusate Sodium (treat constipation) 100 mg one capsule 4. Ferrous sulfate (used to treat and prevent iron deficiency anemia [lack of red blood cells]) 325 mg, one tablet 5. Fludrocortisone (a corticosteroid, used to help control the amount of sodium and fluids in the body) 0.1 mg, two tablets 6. MiraLAX 17 gm (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 concurrent Medication Pass observation and interview on 11/20/2024 at 10:44 a.m. with LVN 1, LVN 1 after preparing Resident 48's medications entered the resident's room. LVN 1 stated he added five oz of water to the MiraLAX Powder, and the powder was observed undissolved at the bottom of the medication cup. Resident 48 began sipping the undissolved MiraLAX while taking the oral pills. LVN 1 stated he would let Resident 48 drink some of the MiraLAX and then add more water. LVN 1 was stopped and asked to fully mix and dissolve the MiraLAX before continuing to administer to Resident 48. During an interview on 11/20/2024 at 11:06 a.m., with LVN 1, LVN 1 stated he was supposed to check resident's (Resident 48) BP right before administering the BP medication when there was an ordered parameter to indicated when to administer or hold the BP medication. LVN 1 stated Resident 48's BP could change or drop, which could lead to the resident experiencing a fall or injury. During an interview on 11/20/2024 at 11:10 a.m., with LVN 1, LVN 1 stated he should have fully dissolved the MiraLAX Powder before allowing Resident 48 to drink it. During a concurrent interview and record review on 11/21/2024 at 9:46 a.m., with the Director of Nursing (DON), Resident 29 and Resident 48's physician orders were reviewed. The DON stated the licensed nurse must take the resident's (that include Resident 29 and Resident 48) BP first and then administer the medication if within the parameters per physician's order to administer. The DON stated residents BP could change and be low or high, if the resident's BP was low giving the BP medication could cause the resident to experience dizziness, increase risk for falls, change of condition, and possible to lead to hospitalization . DON stated licensed nurse needs to mix MiraLAX thoroughly prior to administering to the resident (Resident 48). During a concurrent interview on 11/21/2024 at 9:54 a.m., with the DON, the DON provided and read the manufacturer's specification for MiraLAX preparation that indicated: Mix with 4 to 8 oz of any beverage, hot or cold temperature Stir and dissolve one packet of powder in 4 to 8 ounces of any beverage, hot or cold Ensure that the powder is fully dissolved before drinking Do not drink if there are any clumps. 3. During a review of Resident 42's Admission Record, the Admission Record indicated Resident 42 was admitted to the facility on [DATE]. With diagnosis of type 2 diabetes mellitus (DM - a group of disease that result in too much sugar in the blood). During a review of Resident 42's Physician Order Summary Report, included an order for metformin oral tablet, instructions indicated to give 1000 mg by mouth two times a day for DM. Take with food/meals, order date 10/24/24 During a Medication Pass observation on 11/20/2024 at 11:14 a.m., on Station 1 at MedCart 1 with a Registered Nurse (RN) 1, RN 1 prepared and administered to Resident 42 ten medications which included a medication to treat DM, metformin without food or a meal as ordered by the physician. RN 1 prepared the following medications for Resident 42: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Aspirin 81 mg, 1 tablet 2. Bethanechol (treat urinary and bladder problems) 25 mg, 1 tablet 3. Biotin (supplement) 1000 mcg, 1 tablet 4. Clopidogrel (an antiplatelet, used to prevent blood clots from forming) 75 mg, 1 tablet 5. Lisinopril (lower blood pressure) 40 mg, 1 tablet 6. Metformin (lower blood glucose (a type of sugar) 1000 mg, 1 tablet 7. Metoprolol Tartrate (lower blood pressure) 50 mg, 1 tablet 8. Multivitamin (supplement), 1 tablet 9. Vitamin D3 (supplement) 25 mcg (1000 IU) 1 tablet 10. Heparin (a substance medication that slows the formation of blood clots) 5000 international units (IU, standardized unit of measure)/ milliliter ([ml] - a unit of measure for volume), one ml. During an interview on 11/20/2024 at 2:57 p.m., with RN 1, RN 1 stated he did not give Resident 42's metformin with food or a meal. RN 1 stated must give Resident 42's metformin with food according to the physician's order and to prevent the resident from experiencing an upset stomach. During a concurrent interview and record review on 11/21/2024 at 10:32 a.m., with the DON, Resident 42's physician order for metformin was reviewed. The DON stated Resident 42's order indicated to administer metformin with food or a meal. The DON stated by administering metformin without food or a meal could cause Resident 42 to experience side effects that include diarrhea, nausea, and upset stomach. The DON stated by taking metformin with a meal can help reduce the side effects for the resident. During a review of the facility's Policy and Procedure (P&P) titled, Administering Medications, revised 3/2022, indicated, Medications must be administered in accordance with the orders .The following information must be checked/verified for each resident prior to administering medications .Vital signs, if necessary. During a review of the facility's P&P titled, General Dose Preparation and Medication Administration, revised 1/2013, indicated, Follow manufacturer medication administration guidelines (e.g.providing medication with fluids or food .)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 38740 Based on observation, interview and record review, the facility failed to ensure the standardized recipes for lunch menu was followed on 11/19/202024 when: 1.Facility failed to ensure five residents on mechanical soft chopped diet (for residents who have limited chewing ability and intact swallowing ability) received Chicken alfredo texture in the form that meet their needs when the broccoli was not chopped and there were large pieces of chicken and pasta in the Chicken alfredo. (chicken measured at 1.5 inches using a ruler). 17 residents who were on mechanical soft ground diet received chopped chicken alfredo instead of the ground chicken alfredo per the food production guides (food portion and serving guide). These failures had the potential to result in meal dissatisfaction, decreased nutritional intake, weight loss and increased risk of choking for the residents who were on mechanical soft chopped and or ground diet. Findings: 1.During an observation in the kitchen on 11/19/202024 at 11:50 a.m., [NAME] 1 was mixing the sauce for the Chicken alfredo and preparing the chopped diet. [NAME] 1 stated the chopped Chicken alfredo was served with pasta and it was for residents on mechanical soft chopped or ground diet. Cook1 stated the pieces of the chicken, and the pasta should be about one inch long for the chopped diet. Cook1 stated the residents on ground diet receives the same chopped chicken. During an observation of the tray line service for lunch on 11/19/2024 at 12:00 p.m., the chopped Chicken alfredo had large chunks of chicken. The broccoli florets were big and not chopped. During the same observation for lunch service on 11/19/202024 at 12:00 p.m., residents on ground diet received the chopped Chicken alfredo with pasta there was no ground Chicken alfredo prepared. During an observation in the kitchen for lunch service on 11/19/202024 at 12:40 p.m., one plate was returned to kitchen requesting chopping the broccoli and chicken into smaller pieces. During an interview with Cook1 on 11/19/202024 at 12:45 p.m., Cook1 stated based on her understanding of the menu, all resident on the mechanical soft diet which includes chopped and ground diet, will receive the same food which was chopped Chicken alfredo with pasta today. Cook1 stated she chopped the chicken and pasta into one inch size using a knife. During an interview with [NAME] 1 and review of the production guides for noon meal dated 11/19/202024, Cook1 looked at the production guide and stated according to the guide [NAME] 1 should prepare five servings of chopped chicken alfredo and 17 servings of ground chicken alfredo. [NAME] 1 stated he thought all residents will receive the same chopped chicken alfredo with pasta. [NAME] 1 stated he should have prepared ground chicken alfredo and ground pasta. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and taste test on 11/19/202024 at 1:00 p.m., for the mechanical soft chopped chicken alfredo and pasta with dietary supervisor (DS), the chopped chicken and pasta contained inconsistent sizes of chicken and pasta. There were some large pieces of chicken and pasta on the plate. The broccoli florets were not chopped. The size of the pieces of food was measured using a measuring tape and the chicken was at 1.5 inches long and the broccoli was at 2 inches long. During an interview on 11/19/202024 at 1:00 p.m., with DS, DS stated for the chopped diet, the chicken should be chopped into less than one inch long and the ground should be ground like ground beef. DS stated [NAME] 1 should have used the food blender to chop the chicken into smaller pieces. DS stated the residents on chopped and ground diet received large pieces of chicken. when the resident eats large pieces of chicken they can choke. DS stated he will in-service staff to make sure to follow the food production guide when serving meals. During an interview on 11/19/202024 at 2:00PM, with Registered Dietitian (RD), RD stated for chopped diet, the food should be chopped into half inch pieces. RD stated it was for our residents who require less chewing. RD stated resident on the ground diet, the food is served ground same consistency as ground beef. RD stated when the pieces are large the food can hardly get down and it will be hard for residents to swallow. During an interview on 11/20/202024 at 10:30 a.m., with Speech Therapist (SLP), SLP stated she orders the appropriate diet for the residents per their chewing and swallowing evaluation. SLP stated ground diet is when the meats are ground consistency and sometimes the vegetables can also be ground. SLP stated the Mechanical soft chopped diet, the meat is chopped. SLP cannot remember exactly how small the meat is chopped in the chopped diet. During a review of facility policy and procedure (P&P) titled Mechanical Soft/Ground (dated 4/2024) indicated, This order is for residents who have limited chewing ability and intact swallowing ability .All meat (such as beef, fish, poultry and pork) should be ground or chopped .some cooked vegetables may need to be chopped .Chopped is half inch - half inch pieces, Ground is 1/8 inch or less - consistency of ground meat During a review of the facility's P&P titled Menu (dated 11/2017) indicated, Residents receive food in the amount, type, consistency, and frequency to maintain normal body weight and acceptable nutritional values. During a review of the recipe for chicken alfredo indicated for mechanical soft chop or grind meat to desired texture. During a review of the recipe for broccoli florets indicated for mechanical soft chop portions prior to service. During a review of the production guide for the noon meal dated 11/19/202024 indicated to prepare five serving of chopped chicken alfredo and 17 servings of ground chicken alfredo.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on observation, interview, and record review, the facility failed to ensure residents, who were on pureed (food that had been mashed, ground, crushed until it is smooth and has the consistency of a creamy paste) diet received food consistent with diet order and according to the pureed menu recipe for one of 12 sampled residents (Resident 25. This failure had the potential to put Resident 25 at high risk for aspiration (condition when food, liquid, or other material enters a person's airway [passageway for air] and eventually the lungs), choking (life threatening condition where an object such as food lodges in the throat blocking the flow of air), and possible death. Findings: During a review of Resident 25's Admission Record, the Admission Record indicated Resident 25 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), paroxysmal atrial fibrillation (fast, irregular heartbeat that occurs suddenly and typically last for a short time), chronic kidney disease stage 3 (kidneys are moderately damaged and are not filtering waste and fluid from the blood as it should be), pulmonary hypertension(condition that affects the blood vessels in the lungs that makes the heart work harder than normal to pump). On 7/14/2020 Resident 25 had a diagnosis of moderate protein -calorie malnutrition (state of inadequate intake of food- during resident stay in the facility). During a review of Resident 25's Minimum Dat Set (MDS- resident assessment tool) dated 11/2/2024, the MDS indicated Resident 25 had severe cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated Resident 25 was dependent (helper does all of the effort) on staff with bed mobility, bathing, toileting hygiene, personal hygiene, dressing, and transfer to and from the bed to chair. The MDS indicated Resident 25 weigh was 120 lbs. and height were 65 inches. The MDS indicated Resident 25 was not on a physician's prescribed weight loss regimen. The MDS indicated Resident 25 had five percent (%) weight loss or more in the last month or loss of 10 % or more in the last 6 months. During a review of Resident 25's Physician Order Summary Report dated 8/9/2024, the Physician Order Summary Report indicated Resident 25 on Regular Pureed texture diet, thin liquid consistency, eight ounces super milk (type of milk that is higher in protein and fat than regular milk) three times a day with meals; four ounces (oz-unit of measurement) of prune juice at breakfast, super cereal (fortified wheat, soy, milk that is processed and packed) at breakfast, ice cream lunch and dinner. During a review of Resident 25's Care plan, titled At Risk for Altered Nutrition/Hydration Status initiated 5/18/2021and revised on 8/2/2022, the Care Plan's goals included Resident 25 will adhere to therapeutic diet through review date of 8/8/2024. The Care Plan interventions included to monitor, document, and report signs and symptoms of dysphagia (difficulty of swallowing) like pocketing 9holds on food in the mouth without swallowing), choking, coughing, drooling, holding food in mouth, several attempts in swallowing, refusing to eat and appearing concerned at meals. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview) on 11/20/2024, at 1:15 p.m. with Certified Nursing Assistant (CNA 3) observed of Resident 25's ate some of the pureed potatoes, while pureed green and pureed meat were untouched CNA 3stated he fed Resident 25 who consumed the milk, juice, few bites of pureed potatoes and peanut butter and jelly (PBJ) sandwich. During a review of Resident 25' meal tray ticket dated 11/21/2024, the meal tray ticket indicated Resident 25 on controlled carbohydrate diet (CCO- meal plan that involves eating the same amount of carbohydrates at each meal and snack to help manage blood sugar), pureed texture, thin liquid consistency and no added salt (NAS- a diet where no additional salt is added to food during preparation). The meal ticket tray indicated Resident 25 had no food dislikes and likes peanut butter and jelly sandwich. During a review of Speech Therapy Evaluation and Plan of Treatment dated 8/9/2024, the Speech Therapy Evaluation and Plan of Treatment indicated Resident 25 had dysphagia and diabetes mellitus and for the treatment of swallowing dysfunction and oral function for feeding. During a review of Resident 25's Speech Therapy Discharge Summary dated 8/26/2024, the Speech Therapy Discharge Summary indicated the diet recommendations was pureed consistencies and thin liquid and required close supervision for oral intake. During an interview on 1/21/2024, at 2:49 p.m. with CNA 3, CNA 3 stated Resident 25 had PBJ sandwich for lunch and had eaten all the sandwich. CNA 3 stated the resident is on puree diet with a sandwich. During a concurrent interview and record review on 11/21/1014, at 12:52 p.m. with Dietary Manager (DM), reviewed Resident 25's electronic health record (EHR). DM stated Resident 25 was not receiving the right diet because the resident supposed to receive pureed texture diet. DM stated peanut butter and jelly was not part of a pureed diet and the facility should have requested another speech therapy evaluation (speech therapist evaluate resident swallowing and recommend feeding strategies and appropriate food consistencies). DM stated the PBJ sandwich was already in the meal tray ticket, and he did not have enough time to check and verify Resident 25's diet. DM stated Resident could be at risk for choking and aspiration if physician's order and speech therapist's recommendation was not followed. During a telephone interview on 11/21/2024, at 2:39 p.m., and subsequent interview on 11/21/1014 at 4:13 p. m. with Speech Language Pathologist (SLP), SLP stated she received a referral for Resident 25 who was having difficulty in swallowing last August 2024. SLP stated her recommendation was pureed diet for easier chewing and Resident 25 used to be on mechanical soft diet (soft and moist food that are easy to chew and swallow) but was having difficulty of chewing and had trouble manipulating the food in her mouth. SLP stated large portion of food would be difficult for Resident 25 to chew and swallow. SLP stated pureed texture did not include PBJ sandwich and the facility should have asked another evaluation of Resident 25's swallowing or a referral to speech therapist before giving PB and J sandwich to ensure appropriateness of diet and for residents' safety. SLP stated PBJ sandwich was part of a mechanical soft diet and providing her a PBJ sandwich without proper evaluation and assessment of swallowing could lead to aspiration and weaker muscles could make her aspirate the food. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility's policy and procedure (P&P) titled Therapeutic Diet revised 3/2023, the P&P indicated The facility will ensure residents will receive and consume foods in the appropriate form and the appropriate nutritive content as prescribed by the physician to support the resident's treatment, plan of care , and in accordance with his goals and preferences. The P&P indicated a mechanically altered diet means one in which the texture of a diet is modified, the type of texture modification should be specific and part of the physician's order or licensed dietician order.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38740 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: 1.Nutritional supplement labeled store frozen with manufactures instruction to use within 14 days of thawing, were not monitored for the date they were thawed to ensure expired shakes were discarded after this time frame. One box 30 single serve cartons of vanilla flavored high protein nutrition supplement and another box with 30 single serve cartons of sugar free chocolate high calorie nutrition supplements were stored in the walk-in refrigerator with no thaw date. This failure had the potential to result in food borne illnesses (any illness resulting from eating contaminated/spoiled foods) in 16 residents who were receiving nutrition supplements at the facility. 2.One large tray of boneless chicken thighs thawing on the bottom rack with no thaw date. 3.One bottle of thickened water stored in the reach in refrigerator with open date of [DATE] exceeding storage period for the thickened water. 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 food borne illnesses in 68 out of 70 residents who receive food from facility. Findings: 1.During an observation in the kitchen on [DATE] at 9:00 a.m., there was one box with 30 single serve cartons of vanilla flavor nutrition supplement and another box with 30 single serve sugar free chocolate flavored nutrition supplement stored in the walk-in refrigerator with no date. During a concurrent interview with Dietary Supervisor (DS) stated the supplements are delivered frozen and was stored in the freezer, every two days facility goes through the whole box and there was a fast turn over. DS stated once they were thawed the product was safe for 14 days. DS agreed there should be a date on the supplements to monitor date of thaw and when to discard. 2.During an observation in the kitchen on [DATE] at 9:00a.m., there was one large tray with raw boneless chicken thighs thawing on the bottom shelf in the walk-in refrigerator. There was no date on the chicken, and it was soft to touch. During a concurrent observation and interview with DS, DS stated the chicken was pulled out of the freezer and was thawing in the walk-in refrigerator. DS does not know when the chicken was removed from the freezer. DS stated there should be a thaw date to make sure food was stored safely and then cooked. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with cook (Cook 1) on [DATE] at 9:30 a.m., [NAME] 1 stated she removed the chicken from the freezer this morning and place them in the walk-in refrigerator to thaw. [NAME] 1 stated she was rushing and forgot to mark the thaw date on the chicken. [NAME] 1 stated when there was no thaw date on the food then food was not stored safely, and it can exceed storage period for chicken in the refrigerator. During an observation in the kitchen on [DATE] at 9:35a.m., there was one bottle of honey thickened water (honey-thick liquids pour slowly like honey or molasses for people who have difficulty swallowing) stored with open date of [DATE] and manufacturers use by date of [DATE]. During a concurrent interview with DS and Dietary aide (DA1), DS stated the honey thickened water was expired and should have been discarded. DS reviewed the manufacturer recommendation use by date on the bottle and verified that it was exceeding the storage period for the honey thickened water and discarded the bottle of the thickened water. DS stated when food or beverage exceeds use by date it decreases the quality and can be food safety issue. During the same observation and interview on [DATE] at 9:35 a.m., DA 1 pointed to single serve containers of thickened water and stated, residents receive single serve containers of honey thickened water, DA 1 stated we don't use the bottle and we forgot to discard it. During a review of facility policy and procedure (P&P) titled Food Receiving and Storage (revised ,d+[DATE]) indicated, Practices to maintain safe refrigerated storage include: labeling, dating and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use by date, or frozen or discarded. During a review of the 2022 U.S. Food and Drug Administration Food Code titled Ready to Eat, Time/Temperature control for safety food, Date Marking Code#,d+[DATE].17, indicated, Ready to eat, time temperature control for safety food prepared and packaged by food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 2024 hours, to indicate the date or day by which the food shall be consumed, sold, or discarded.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45382 Based on observation, interview, and record review, the facility failed to ensure clinical records were accurately documented for one of five samples residents (Resident 2). The facility failed to: a Ensure Resident 2's Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) discharge recommendations for a resting hand splint (splint [rigid material or apparatus used to support and immobilize a broken bone or impaired joint] secured from the hand to the forearm to position the hand in a functional position) to Resident 2's left arm and a hand roll splint (splint placed in the palm of the hand used to position the hand in a functional position) to Resident 2's right hand to be worn for four (4) hours on and 4 hours off (removed) on 6/28/2024 were accurately documented. b.Ensure the range of motion (ROM, movement ability of a joint) status of Resident 2's both hands were accurately documented in the OT Evaluation, dated 6/26/2024. These failures had the potential to negatively impact the provision of necessary care and services for Resident 2. Findings: During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including right sided hemiplegia (weakness to the right side of the body) and hemiparesis (inability to move one side of the body) following a non-traumatic intracerebral hemorrhage (bleeding in the brain) and contractures (loss of motion of a joint associated with stiffness and joint deformity) of both hands and the lower leg. During a review of Resident 2's Physician Order Summary Report, the Physician Order Summary Report indicated a physician's order, dated 6/26/2024, for OT to evaluate Resident 2 to prevent further contractures (loss of motion of a joint associated with stiffness and joint deformity) of both hands. During a review of Resident 2's OT Evaluation and Plan of Treatment (OT Eval), initiated 6/26/2024, the OT eval indicated the reason for referral was due to a decline in ROM of Resident 2's both hands. The OT Eval indicated Resident 2 had impaired ROM in both shoulders and both hands and had rigid muscle tone (the amount of tension or resistance to movement in muscles) in both arms. The OT Eval indicated Resident 2 had contractures of both hands. The OT Eval indicated the OT recommended Resident 2 to wear a resting hand splint on the left hand and a hand roll on the right hand for 4 hours on and 4 hours off to maintain joint integrity and manage muscle tone. The OT Eval indicated short-term goals for Resident 2 to safely wear a resting hand splint on the left hand and a hand roll splint on the right hand for up to two hours with minimal redness, swelling, discomfort or pain. The OT Eval indicated long-term goals for Resident 2 to safely wear a resting hand splint on the left hand and a hand roll splint on the right hand for up to 4 hours with minimal redness, swelling, discomfort or pain. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's OT Discharge Summary, dated 6/28/2024, the OT Discharge Summary indicated Resident 2 was discharged from OT services due to transfer to Hospice care (care focused on comfort and quality of life of a person with a serious illness who is approaching the end of life). The OT Discharge Summary indicated Resident 2 tolerated 30 minutes of safely wearing both the resting hand splint on the left hand and a hand roll splint on the right hand at the time of discharge. The OT Discharge Summary indicated the OT recommended Resident 2 to wear a resting hand splint on the left hand and a hand roll on the right hand for 4 hours on and 4 hours off to maintain joint integrity and manage muscle tone. During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 10/2/2024, the MDS indicated Resident 2 had severely impaired cognitive (ability to think, understand, learn, and remember) skills for daily decision making. The MDS indicated Resident 2 was dependent in eating, hygiene, bathing, dressing, rolling to both sides, and transfers. The MDS indicated Resident 2 had functional limitations in ROM (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in both arms and both legs. During an observation on 11/19/2024 at 2:31 p.m., in Resident 2's room, Resident 2 was lying in bed with both elbows slightly bent with rolled up towels positioned in both hands. During a concurrent interview and record review on 11/21/2024 at 1:10 pm, the Director of Rehabilitation (DOR) who was the OT who evaluated Resident 2 reviewed Resident 2's OT therapy notes. The DOR stated the physician referred OT to evaluate Resident 2 on 6/26/2024 for contracture management of both hands. The DOR reviewed Resident 2's OT Eval, dated 6/26/2024, and confirmed he documented Resident 2 had contractures of both hands. The DOR stated the documentation of the presence of contractures to Resident 2's both hands were inaccurate because Resident 2 did not have contractures. The DOR stated he did not know why he documented Resident 2 had contractures when she did not. The DOR confirmed OT recommended Resident 2 wear a left resting hand splint and a right-hand roll splint for 4 hours on and 4 hours off upon discharge from OT services on 6/28/2024. The DOR stated the OT discharge recommendations for splinting were inaccurate because Resident 2 was never issued hand splints upon discharge as recommended and was unable to safely tolerate wearing both hand splints for 4 hours. The DOR confirmed Resident 2 tolerated 30 minutes of wearing both hand splints at the time of discharge and should not have recommended on the OT Discharge Summary for Resident 2 to wear both hand splints for 4 hours on and 4 hours off because she would not be able to safely tolerate that amount of time. The DOR stated he accidentally documented the recommendation for both hand splints with a 4-hour wear time because he was not paying attention when he was writing the OT Discharge Summary. The DOR stated it was important documentation in a resident's clinical was accurate because it could potentially cause confusion, harm, and create an inaccurate picture of a resident's current level of function and needs. During an interview on 11/22/2024 at 10:14 am, the Director of Nursing (DON), the DON stated it was important for all documentation in a resident's clinical record to be accurate because it reflected the resident's status and ensured the facility provided the resident with all necessary care and services. The DON stated if documentation was inaccurate, it could potentially lead to confusion, an inaccurate picture of a resident's current level of function and could ultimately result in a functional decline because the residents may not receive the services they need. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's undated OT Job Description, titled Registered OT Job responsibilities, the Job Description indicated OT documented patient care services by charting in the patient and department record and evaluated results of OT by observing, noting, and evaluating patient's progress, recommending, and implementing adjustments and modifications. During a review of the facility's policy and procedure (P&P), titled Documentation Policy, revised 3/2023, the P&P indicated it was the facility's policy to document relevant findings in the clinical record.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 44898 Based on interview and record review the facility's Quality Assessment and Assurance (QAA committees established for the purpose of improving the safety and quality of health services) and Quality Assurance Performance Improvement (QAPI- approach to maintain and improve safety and quality in nursing homes) committee failed to implement corrective action to the potential systemic problems identified: 1. Maintain a system to monitor weight loss. 2. Maintain a system to ensure the reporting of falls with major injury. 3. Maintain a system to ensure pressure injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) preventive measures were implemented. Findings: During an interview on 11/23/2024 at 4:40 p.m., with the Director of Nursing (DON), the DON stated the QAA discuss monthly falls, pressure injuries and weight loss. The DON stated there was a need for improvement and will be working on the issues identified as deficient practices. During a review of the facility's policy and procedures (P&P) titled, Quality Assurance Performance Improvement, revised dated 3/2023, the P&P indicated the facility's Purpose Statement was, To provide facility staff with a plan that describes the process for conducting QAPI/QAA activities, such as identifying and correcting quality deficiencies as well as opportunities for improvement, which will lead to improvement in the lives of nursing home residents, through continuous attention to quality of care, quality of life, and resident safety.