STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555831	A. Building B. Wing	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Herman Health Care Center	2295 Plummer Avenue San Jose, CA 95125

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on observation, interview, and record review, the facility failed to ensure respect and dignity was maintained for seven of 24 sampled residents (Residents 28, 84, 55, 621, 46, 40, and 52) when: 1. Staff provided feeding assistance to Residents 28 and 84 while standing; 2. Staff failed to provide privacy bags for Residents 55 and 621's urinary bags; 3. Resident 46's privacy was not maintained during patient care; 4. Resident 40's dignity was not maintained by staff; and 5. Staff did not provide a privacy curtain inside Resident 52's room. These failures had the potential to affect the emotional and psychosocial well-being of the residents. Findings: 1a. Review of Resident 28's Minimum Data Set (MDS, an assessment tool) 5-day assessment, dated 1/15/2024, indicated her cognition was severely impaired and she required partial/moderate assistance (helper does less than half the effort) on staff for eating. During lunch meal observation on 2/12/2024 at 12:29 p.m., Resident 28 was in her room, lying in bed. Certified Nurse assistant H (CNA H) stood beside Resident 28 while providing spoon-feeding assistance. During a follow up interview with CNA H at 12:32 p.m., CNA H confirmed she was standing while feeding Resident 28. CNA H stated she should have been sitting down when she was feeding residents to show some respect. 1b. Review of Resident 84's MDS Quarterly assessment, dated 12/18/2023, indicated her cognition was severely impaired. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent lunch meal observation and interview with CNA I on 2/12/2024 at 12:35 p.m., Resident 84 was in her room, lying in bed. CNA I stood beside Resident 84 while providing spoon-feeding assistance. CNA I confirmed she was standing while feeding Resident 84. CNA I stated she should have sit down when feeding residents. During an interview with Licensed Vocational Nurse F (LVN F) on 2/15/2024 at 9:32 a.m., LVN F stated, CNA should have sit beside the resident when feeding them for their integrity. During a review of the facility's policy and procedure titled, Assistance with Meals, date revised March 2022, indicated, Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: a. not standing over resident while assisting them with meals . 46553 2a. Review of Resident 55's clinical record indicated, he was admitted on [DATE] with diagnoses that included hemiplegia (muscle weakness) and hemiparesis (one sided muscle weakness), reflux uropathy (a condition in which urine regurgitates [backward flowing] from the bladder back into the ureter), epileptic seizure (recurrent seizure, brief involuntary movement involve part of the body). Review of Resident 55's clinical record indicated a physician order of indwelling urinary (Foley) catheter, dated 10/02/22. During an observation on 2/12/24 at 9:01 a.m., Resident 55 was lying in bed. The urine collection bag for his indwelling catheter was hanging on the right side of his bed. The urine collection bag was not covered, and the contents were visible. During observation on 2/12/24 at 12:29 p.m., Resident 55's urine collection bag was not covered. 2b. Review of Resident 621's clinical record indicated, he was admitted on [DATE] with diagnoses that included low back pain, cellulitis (bacterial skin infection), retention of urine, sciatica (pain, weakness, numbness caused by injury or pressure to sciatic nerve). Review of Resident 621's clinical record indicated a physician order of indwelling urinary (Foley) catheter, dated 2/13/24. During an observation on 2/12/24 at 9:24 a.m., Resident 621 was lying in bed. The urine collection bag for his indwelling catheter was hanging on the left side of his bed. The urine collection bag was not covered, and the contents were visible. During a concurrent observation and interview on 2/12/24 at 9:30 a.m., with CNA G, stated it was always like that I don't see any covered for the catheter, never seen that is covered. During a concurrent observation and interview with LVN C on 2/12/24, at 9:33 p.m., inside Resident 55 and 621 's room, LVN C verified Resident 55 and 621's urine collection bag was not covered. LVN C stated the urine collection bag should have been covered with a privacy bag. During an interview on 2/16/24, at 1:11 p.m., with Director of Nursing (DON) A, the DON A stated urine collection bag should have been covered for privacy of the resident. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During review of the facility's policy and procedure (P&P) titled, Dignity , revised 2/2021, the P&P indicated, 12a. helping the resident to keep urinary catheter bags covered. 46939 3. During an observation on 2/12/24, at 10:48 a.m., in Resident 46's room. Licensed Vocational Nurse (LVN) P gave Resident 46 his medication through his Gastrostomy tube (a tube inserted through the abdomen that brings nutrition directly to the stomach) without closing Resident 46's privacy curtain around his bed, or the door to his room, three other residents were noted in the room at the time. Resident 46's abdomen and waist were exposed for other residents and visitors to see. During an interview on 2/12/24, at 11 a.m., with LVN P, LVN P stated, she did not close the privacy curtain or the door prior to giving patient care to Resident 46, and she should have. During an interview on 2/16/24, at 1:12 p.m., with Director of Nursing (DON) A, DON A stated, staff should close the privacy curtains prior to giving patient care. 4. During an interview on 2/14/24, at 2:21 p.m., with Certified Nursing Assistant (CNA) K, outside Resident 40's room, CNA K stated, He won't let me change his diaper, referring to Resident 40. During an interview on 2/16/24, at 1:12 p.m., with DON A, DON A stated, staff should refer to residents in a respectful way. During a review of the facility's policy and procedure (P&P), titled, Dignity, dated 2011, the P&P indicated, Staff speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not 'labeling' or referring to the resident by his or her room number, diagnosis, or care needs. Staff promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. 44733 5. During an observation on 2/12/2024 at 2:00 p.m., Resident 52's room door was opened, and no privacy was observed. Resident 52 was visible from the hallway and was walking in the room with no clothes. Registered Nurse L (RN L) confirmed the observation. RN L stated she was not aware there was no privacy curtain for Resident 52. During an observation on 2/13/2024 at 10:02 a.m., Resident 52's room door was opened, and no privacy was observed. Resident 52 was visible from the hallway, took off her gown, and came out to the hallway with no clothes. Certified Nurse Assistant M (CNA M) assisted Resident 52 to her room. During an observation and interview on 2/13/2024 at 10:10 a.m. with RN N, she confirmed there was no privacy curtain in Resident 52's room. RN N stated Resident 52's privacy curtain was not replaced for the resident's safety after she had torn her privacy curtain off, but she was not sure about the details. RN N further stated there was no evidenced documentation about the reason why Resident 52 didn't have a privacy curtain in her room. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 2/15/2024 at 9:05 a.m. with Licensed Vocational Nurse F (LVN F), she confirmed there was no privacy curtain in Resident 52's room. LVN F stated that Resident 52 should have a privacy curtain for privacy. During an interview and record review on 2/15/2024 at 9:09 a.m. with LVN F, she confirmed there was no documentation about not providing a privacy curtain to Resident 52 for her safety. LVN F stated the facility should have a privacy curtain unless there was a documented safety risk, and it should have been offered alternatives to provide privacy if the privacy curtain had a safety risk. During a review of the facility's policy and procedure (P&P) titled Dignity, revised 2/2021, the P&P indicated, Staff promote, maintain and protect privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. 27000 Based on interview and record review, the facility failed to ensure the informed consent (process in which a health care provider educates a patient about the risks, benefits, and alternatives of a given procedure or intervention in order to obtain agreement or permission for care, treatment, or services) was in place (or verified) prior to the initiation and administration of psychotropic medication (drugs that affects brain activities associated with mental processes and behaviors) for three of 24 sampled residents (Resident 58, 75, and 370). This deficient practice had the potential for the residents or the responsible party (RP) to not be informed of the risk and benefits of the psychotropic medications, and to make an informed decision, before receiving the medications. Findings: 1. A review of Resident 58's medical record indicated she was admitted to the facility with diagnoses including bipolar disorder (condition associated with episodes of mood swings ranging from depressive lows to manic highs), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and vascular dementia (brain damage caused by multiple strokes). A review of Resident 58's medication orders indicated she had been receiving trazodone (an antidepressant), in various doses, for depression manifested by inability to sleep; and Cymbalta (antidepressant) 30 mg, 1 capsule daily at bedtime for major depressive disorder, since admission in September 2020. Further review of Resident 58's electronic or paper medical records reflected no informed consents were obtained or verified for both trazodone and Cymbalta. During a concurrent interview and record review with Director of Nursing (DON) B on 2/15/24 at 1:10 p.m., she reviewed Resident 58's medical record and stated she could not locate the informed consent for trazodone and Cymbalta. During a follow-up interview with DON B on 2/16/24 at 1:20 p.m., she stated she had the help of medical record staff and looked through the old paper records but could not locate the missing informed consent forms. She stated the facility staff should have made sure the psychotropic informed consent forms were in the chart before they administered the medications to the residents. 2. Resident 75 was admitted to the facility with diagnoses including unspecified dementia and cognitive communication deficit. A review of Resident 75's physician's orders indicated she had been receiving: - Depakote (medication to treat mood disorder) 250 mg twice daily and 375 mg at bedtime for dementia with agitation, dated 10/25/23; and (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Escitalopram (an antidepressant) 10 mg daily for depression, dated 6/13/23. A review of Resident 75's medical record indicated no evidence the facility staff verified the informed consent was obtained for these two medications. During a concurrent interview and record review with DON B on 2/16/24 at 10:15 a.m., she reviewed Resident 75's electronic and paper medical records and stated, None that I can see here. I checked all the pages here in the chart. It should be part of the admission. During a follow-up interview on 2/16/24 at 1:21 p.m., DON B stated she could not locate the informed consents for Resident 57's Depakote and escitalopram. She stated she called Resident 57's RP who is aware of the resident's medications. She confirmed the nursing staff should have verified the informed consent was obtained before they administered the psychotropic medications. 3. A review of Resident 370's medical record indicated he was admitted to the facility with diagnoses including bipolar disorder. His medication orders included: - Aripiprazole (an antipsychotic medication) 25 mg daily for bipolar disorder manifested by abrupt changes in behavior from calm to sudden loud outbursts, dated 1/9/24 - Trazodone 100 mg 1 tab at bedtime for bipolar with depressive episodes, dated 1/8/24. There was no documented evidence in Resident 370's medical record the facility staff verified the informed consents for these two medications. During a concurrent interview and record review with DON B on 2/16/24 at 10:38 a.m., she reviewed Resident 370's electronic and paper medical record and confirmed there were no informed consent forms for the above medications. During a follow-up interview on 2/16/24 at 1:21 p.m., DON B stated she could not find any informed consent forms for Resident 370's psychotropic medications, spoke with resident, and he was fully aware of his psychotropic medications. She acknowledged the informed consent forms should be in the medical record before the medications were administered. A review of the facility's Informed Consent Nursing Manual - General, dated 7/8/2016, indicated, Each time a new order for a psychotropic drug is obtained, the Licensed Nurse verifies with the resident and/or legal representative that informed consent has been obtained. The Licensed Nurse documents this verification on . Form C- Informed Consent Verification.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on observation, interview, and record review, the facility failed to ensure resident's needs were accommodated for five of 24 sampled residents when: 1. Residents 11, 2, and 18's call light button (a cord with a button used by residents to request assistance) were not within reach to use; 2. Resident 41's call light button was not within reach to use; and 3. Resident 52's call light was broken and unable to use. These failures had the potential to affect these resident's physical and psychosocial well-being. Findings: 1a. Review of Resident 11's face sheet (a document that contains a summary of patient's personal and demographic information) indicated, Resident 11 was admitted to the facility with diagnoses including Alzheimer's disease (a progressive disease that destroys memory and mental functions), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), Bell's palsy (a condition affecting the nerve that controls facial muscles, resulting in facial weakness or paralysis), and hypertensive chronic kidney disease with stage 1-4 (a damage to kidney due to high blood pressure). Review of Resident 11's Minimum Data Set (MDS, an assessment tool) 5-day assessment, dated 11/18/2023, indicated Resident 11 had memory problem. During a concurrent observation and interview with Certified Nurse Assistant O (CNA O) on 2/12/2024 at 10:29 a.m., inside Resident 11's room, Resident 11 was asleep on her bed. Resident's call light button was observed inside her bedside's top drawer. CNA O confirmed Resident 11's call light button was not within reach to use. 1b. Review of Resident 2's face sheet indicated, Resident 2 was admitted to the facility with diagnoses including bipolar disorder (mental disorder characterized by periods of elevated mood and depression, often with poor decision-making), and unspecified dementia (decline in mental capacity affecting daily function). Review of Resident 2's MDS Quarterly assessment, dated 11/15/2023, indicated Resident 2 had memory problem. During a concurrent observation and interview with CNA O on 2/12/2024 at 10:30 a.m., Resident 2 was lying in bed and call light button was on the floor, under her bed. CNA O confirmed Resident 2's call light was not within resident's reach to use. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1c. Review of Resident 18's face sheet indicated, Resident 18 was admitted to the facility with diagnoses including iron deficiency anemia (a condition in which the body does not have enough healthy red blood cells) secondary to blood loss, contracture (a fixed tightening of muscle, tendons, ligaments, or skin) of muscle, multiple sites, specified depressive episodes and manic (state of mind characterized by high energy, and excitement over a sustained period of time) episode. Review of Resident 18's MDS Quarterly assessment, dated 1/10/2024, indicated Resident 18 had memory problem and she had an impairment in one side of the upper extremity (shoulder, elbow, wrist, hand). During a concurrent observation and interview with CNA O on 2/12/2024 at 10:33 a.m., Resident 18 was lying in bed and her call light button was found on the floor, slightly under the bed. CNA O picked up Resident 18's call light button and placed it on Resident 18's right side. Resident 18 was observed to have right sided weakness. CNA O stated resident's call light button should have been always placed within their reach to use. During a concurrent observation and interview with Licensed Vocational Nurse F (LVN F) on 2/16/2024 at 9:53 a.m., Resident 18's call light button was placed to her right side. LVN F confirmed Resident 18 had right sided weakness and right hand was contracted. LVN F stated resident's call light should have been within their reach and it should have been placed near their dominant side or near their functioning hands. During a review of the facility's policy and procedure titled, Answering the Call Light, date revised September 2022, indicated, The purpose of this procedure is to ensure timely responses to the resident's requests and needs .Ensure that the call light is accessible to the resident when in bed . 44733 2. A review of Resident 41's clinical record indicated she was admitted on [DATE] and had diagnoses including psychosis (a mental illness), dementia (a decline in mental capacity affecting daily functioning), and hypertension (high blood pressure). Her minimum data set (MDS, an assessment tool) dated 12/18/2023 indicated she had a brief interview of mental status (BIMS, a structured cognitive test) scoring 99 (the resident was unable to complete the interview). During an observation on 2/13/2024 at 10:15 a.m., Resident 41 was lying in bed, and her call device was not within reach and was tied to the right side of the side rail. During an observation and interview on 2/13/2024 at 11:57 a.m. with Certified Nurse Assistant Z (CNA Z), she confirmed the observation and stated Resident 41 was not able to use the call device, and there was no need to put the call device within reach for the resident. During an interview on 2/15/2024 at 11:57 a.m. with the Minimum Data Set Coordinator (MDSC), he acknowledged that the residents should have a call device, and the facility should have provide an alternative means to communicate if the resident was not able to use the call device. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident 52 was admitted on [DATE] with diagnoses including hemiplegia following cerebral infarction (damage to the brain tissues, also known as a stroke) affecting left nondominated side, mood disorder (a mental health condition), type 2 diabetes (high blood sugar), and chronic obstructive pulmonary disease (COPD, a disease that affects airflow in the lungs and makes it difficult to breathe). During a review of Resident 52's Minimum Data Set (MDS, an assessment tool) dated 1/22/2024, the MDS indicated she had a brief interview of mental status (BIMS, a structured cognitive test) scoring 03 (severe cognitive impairment). During an observation on 2/12/2024 at 9:59 a.m., Resident 52 was lying in bed, and no call device was observed. During an observation and interview on 2/12/2024 at 10:04 a.m. with Certified Nurse Assistant M (CNA M), she confirmed the observation and stated she did not know why there was no call device for Resident 52. During an interview on 2/12/2024 at 10:08 a.m. with Registered Nurse N (RN N), she confirmed there was no call device for Resident 52. RN N stated the facility removed the call device from Resident 52 related to her self-harming behavior. RN N further confirmed the facility did not offer any alternative means to communicate with Resident 52. During an observation and interview on 2/15/2024 at 9:01 a.m. with Licensed Vocational Nurse F (LVN F), Resident 52 was sitting in a chair in front of her room, and no call device was observed in her room. LVN F confirmed the observation. LVN F started to check Resident 52's room and found the call device behind the resident's closet. LVN F connected the call device to the wall connecter, but it was not working. LVN F stated the facility staff should have reported it for repair instead of putting it away. During an interview and record review on 2/15/2024 at 9:09 a.m. with LVN F, she reviewed Resident 52's clinical record and stated there was no evidenced documentation indicating Resident 52's call device was removed for the resident's safety. LVN F also stated the resident should have a device to call for assistance. During a review of the facility's policy and procedure (P&P) titled Call System, Resident, dated 9/2022, the P&P indicated, Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station. The resident call system remains functional at all times. If the resident has a disability that prevents him/her from making use of the call system, an alternative means of communication that is usable for the resident is provided and documented in the care plan. The resident call system was routinely maintained and tested by the maintenance department.

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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** 44733 Based on interview and record review, the facility failed to follow their abuse policy for one of 24 sampled residents (Resident 52) when staff did not report and investigate Resident 52's allegation of abuse timely. This failure had the potential to compromise Resident 52's safety and delay abuse investigations. Findings: Resident 52 was admitted on [DATE] with diagnoses including hemiplegia following cerebral infarction (damage to the brain tissues, also known as a stroke) affecting left nondominated side, mood disorder (a mental health condition), type 2 diabetes (high blood sugar), and chronic obstructive pulmonary disease (COPD, a disease that affects airflow in the lungs and makes it difficult to breathe). During a review of Resident 52's Minimum Data Set (MDS, an assessment tool) dated 1/22/2024, the MDS indicated she had a brief interview of mental status (BIMS, a structured cognitive test) scoring 03 (severe cognitive impairment). During a review of Resident 52's Nurses Notes dated 1/28/2024 at 2:00 p.m., the note indicated that around 7:30 a.m., resident went out of her room yelling, 'He raped me, he raped me.' resident was unable to identify any person. resident was more disoriented than baseline, pacing and agitated. when writer asked if someone touched her inappropriately, the resident denied. During a review of Resident 52's Nurses Notes dated from 1/28/2024 to 1/31/2024, the nurses notes indicated Resident 52 was on monitoring for false accusations and mood fluctuation. During a review of Resident 52's clinical record on 2/13/2024, the record revealed there was no care plan developed for the allegation of sexual abuse and no interdisciplinary team (IDT, a group of dedicated healthcare professionals who work together to provide the needed care) note initiated. During an interview and record review on 2/13/2024 at 4:01 p.m. with the Administrator (ADM), she reviewed the nurses notes dated 1/28/2024 and confirmed that there was an allegation of sexual abuse from Resident 52. The ADM stated she was not aware of Resident 52's allegations of abuse on 1/28/2024. The ADM stated she was the facility's abuse coordinator, and the allegation of sexual abuse should have been reported to her on 1/28/2024. During an interview and record review on 2/13/2024 at 4:23 p.m. with the Social Services Director (SSD), she reviewed the nurses notes dated 1/28/2024 and confirmed that there was an allegation of sexual abuse from Resident 52. The SSD stated she was not aware of Resident 52's allegations of abuse on 1/28/2024. The SSD stated the allegation of sexual abuse should have been reported to the facility abuse coordinator on 1/28/2024 and investigated. The SSD also stated the facility should have report it and investigate an allegation of abuse regardless of the resident's cognitive level. The SSD further stated the allegation should have been reported to the Police Department, California Department of Public Health (CDPH), and Ombudsman (an official who investigates and helps settle complaints) timely. (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 Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised 9/2022, the P&P indicated, All reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and other officials according to state law. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: the state licensing/certification agency; the local/state ombudsman; law enforcement officials. 'Immediately' is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Herman Health Care Center	2295 Plummer Avenue San Jose, CA 95125

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 27000 Based on interview and record review, the facility failed to ensure the hospital transfer information was documented in the medical record for one of 24 sampled residents (Resident 56). The facility did not document the date and time of transfer, where she was transferred to, how she was transported, and the summary of her condition when she was transferred. The failure resulted in lack of information regarding the resident's transfer, and the potential for not providing necessary care and services to the resident. Findings: A review of Resident 56's medical record indicated she was admitted to the facility with diagnoses including urinary tract infection (UTI). A review of Resident 56's Minimum Data Set (a resident assessment and screening tool), dated 12/15/23, indicated she had a BIMS score of 15 (Brief Interview for Mental Status, a test given by medical professionals that helps determine a patient's cognitive understanding, scored from 1 to 15), which indicated she was cognitively intact. During an interview with Resident 56 on 2/12/24 at 10:46 a.m., she stated she was transferred to the hospital a few days ago, and was prescribed an antibiotic for UTI but the facility has not given it to her. On 2/12/24, a review of a nursing progress notes in Resident 56's medical record, dated 2/9/24 at 9:01 p.m., indicating Resident return to facility on 2/9/24 via ambulance transferred by gurney. However, there was no documentation of the date and time of transfer, how, where, and the description or summary of the resident's condition at the time of transfer to the hospital. During a concurrent interview and record review with the interim Director of Staff Development (IDSD) on 2/12/24 at 3:58 p.m., he reviewed Resident 56's medical record and stated he couldn't seem to pull out that information as to when, where, and how Resident 56 was transferred. During an interview with the Medical Record Director (MRD) on 2/14/24 at 11:57 a.m., she stated she could not find any documentation of when Resident 56 was transferred to the hospital. She stated the resident was cared by registry nurses (licensed or certified staff who receive compensation from a third party agency to work at a nursing care institution), and they probably forgot [to document]. She stated there should be documentation of resident transfer out of the facility but she could not speak for them. A review of the acute care hospital's Discharge Summary, dated 2/9/24, indicated Resident 56 was admitted to the hospital on 2/8/24 at 2052 (8:52 p.m.) for UTI, and discharged from the hospital and transferred back to the facility via ambulance transport on 2/9/24 at 1430 (2:30 p.m.). (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review with Director of Nursing A (DON A) on 2/15/24 at 10:28 a.m. , she stated she saw the notes of the resident returning on 2/9/24 but could not find any documentation of resident being transferred out. She stated she called the registry staff to see why the documentation was not there but they did not call her back. A review of a facility policy and procedure titled Transfer or Discharge, Facility-Initiated, dated 10/2022, indicated: When a resident is transferred or discharged from the facility, the following information is documented in the medical record: a. The basis for the transfer . b. That an appropriate notice was provided to the resident and/or legal representative; c. The date and time of the transfer or discharge; d. The new location of the resident; e. The mode of transportation; f. A summary of the resident's overall medical, physical, and mental condition . j. The signature of the person recording the data in the medical record.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on interview and record review, the facility failed to complete and transmit the Minimum Data Set (MDS, an assessment tool) discharge assessment and death tracking record in a timely manner for three of five residents (Residents 47, 82, and 15). These failures resulted in the resident's discharge assessment and death tracking record not being transmitted and received by the Center for Medicare and Medicaid System (CMS) within the time requirement. Findings: 1. During a concurrent interview and record review with Minimum Data Set Coordinator (MDSC, a nurse who assess and evaluate the quality of care being given to long-term care residents) on [DATE] at 11:37 a.m., MDSC reviewed Resident 47's clinical records. Resident 47's clinical records indicated, Resident 47 was admitted to the facility on [DATE] and was discharged on [DATE] to home. MDSC confirmed the MDS discharge assessment dated [DATE] was completed but not signed by a Registered Nurse Coordinator (RNC) to verify the assessment completion. MDSC further confirmed the MDS discharge assessment was not transmitted to CMS as required. MDSC stated the discharge assessment should have been done within 7 days of resident's discharge and should have been submitted to CMS within 14 days. 2. During another concurrent interview and record review with MDSC on [DATE] at 11:40 a.m., MDSC reviewed Resident 82's clinical records. Resident 82's clinical records indicated, Resident 82 was admitted to the facility on [DATE] and was discharged to another skilled nursing facility (SNF, a facility that provides 24-hour skilled nursing care, as well as related or rehabilitative services) on [DATE]. MDSC confirmed Resident 82's MDS discharge assessment dated [DATE] was not signed by RNC and it was not transmitted to CMS as required. Review of Center for Medicare and Medicaid Services' Long-Term Care Facility Resident Assessment Instrument 3.0 (CMS's LTCF RAI - a guide for facility staff to existing coding and transmission) Version 1.18. 11, dated [DATE], indicated, Federal regulation requires the RN assessment coordinator to sign and thereby certify that the assessment is complete. Further review indicated, the discharge assessment should be completed no later than 14 calendar days from discharge date and the transmission date should be no later than 14 calendar days from the MDS completion date. 3. During a concurrent interview and record review with MDSC on [DATE] at 11:42 a.m., MDSC reviewed Resident 15's clinical records. The clinical records indicated, Resident 15 was admitted to the facility on [DATE] and Resident 15 expired on [DATE]. MDSC confirmed Resident 15's death tracking MDS dated [DATE] was not transmitted to CMS as required. MDSC stated there should be an Accepted status beside the assessment if the MDS was transmitted to CMS. Review of the CMS's LTCF RAI 3.0 Version 1.18.11, dated [DATE], indicated, Death in facility tracking record should be completed no later than 7 calendar days from discharge (death) and the transmission date should be no later than 14 calendar days from discharge (death).

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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** 44733 Based on interview and record review, the facility failed to accurately assess and complete the Minimum Data Set (MDS, an assessment tool) for two of 24 sampled residents (Residents 12 and 46). This failure had the potential to compromise the facility's ability to develop and implement resident-centered care plans and interventions. Findings: 1. A review of Resident 12's physician's order indicated she was admitted to hospice with the admitting diagnosis of heart failure (a chronic condition in which the heart cannot pump blood as well as it should) on 8/21/2023. Resident 12's MDS dated [DATE] was reviewed. Section O0100 asked to check all of the following treatments, procedures, and programs that were performed during the last 14 days, and K. hospice care was not checked. Resident 12's MDS dated [DATE] was reviewed. Section O0100 indicated K. hospice care was not checked. During an interview and concurrent record review on 2/14/2024 at 11:22 a.m. with the Minimum Data Set Coordinator (MDSC), the MDSC reviewed Resident 12's clinical record and confirmed she was admitted to hospice on 8/21/2023. The MDSC acknowledged that hospice care should have been checked on the MDS dated [DATE] and 11/22/2023. The MDSC confirmed the MDS was not accurate because it should have been indicated that Resident 12 was on hospice care during the specified time frame. During a review of Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.18.11 October 2023, the manual indicated, The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that (1) the assessment accurately reflects the resident's status. 44583 2. Review of Resident 46's face sheet (a document that contains a summary of patient's personal and demographic information) indicated, Resident 46 was admitted to the facility with diagnoses including type 2 diabetes mellitus (a condition which affects the way the body processes blood sugar) with hyperglycemia (high blood sugar), vascular dementia (problems with reasoning, planning, judgement, memory and other thought processes caused by brain damage from impaired blood flow to the brain), unspecified severity, encounter for attention to gastrostomy (a surgical opening into the stomach, often referred to as a G-tube, for administration of nutrition and medications), and dysphagia, oropharyngeal phase (swallowing problems occurring in the mouth and/or the throat). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review with MDSC on 2/15/2024 at 11:45 a.m., MDSC reviewed Resident 46's MDS Section K - Swallowing/Nutritional Status for both 5-day assessment dated [DATE] and Quarterly assessment dated [DATE]. MDSC confirmed the MDS 5-day assessment dated [DATE], indicated, Resident 46's weight was 146 pounds and section K0300 (Weight Loss) was coded 2. Yes, not on physician-prescribed weight-loss regimen. Further review of the MDS 5-day assessment MDSC confirmed Resident 46 was getting nutrition thru the feeding tube. MDSC confirmed the weight in Resident 46's Quarterly assessment dated [DATE] was 147 pounds and K0300 was coded 2. MDSC stated Resident 46's Quarterly assessment's section K0300 should have been coded as '0. No or unknown.' MDSC further stated there was no weight loss when the MDS Quarterly assessment was completed. Review of Center for Medicare and Medicaid Services' Long-Term Care Facility Resident Assessment Instrument 3.0 (CMS' LTCF RAI - a guide for facility staff to existing coding and transmission) Version 1.18. 11, dated October 2023, indicated, K0300: Weight Loss .Coding instructions: Code 0, no or unknown: if the resident has not experienced weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days or if information about prior weight is not available .Code 2, yes, not on physician-prescribed weight loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was not planned and prescribed by a physician. Further review indicated, Accurate coding is important for reporting on the type and amount of care provided.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46553 Based on interview and record review, the facility failed to ensure to follow their Policy and Procedure for one of 5 sampled residents (Resident 1) Preadmission Screening and Resident Review (PASSR a federal requirement to help ensure that individuals who have mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care) to reopen and submit annual level I screening. These failures had the potential for inaccurate care and services provided to residents with a mental disorder, intellectual disability, or related conditions. Findings: Review of Resident 1's clinical record indicated he was readmitted on [DATE] and had a diagnoses of cognitive communication deficit (difficulty with thinking and how someone uses language), seizure (a sudden, uncontrolled burst of electrical activity in the brain), paranoid schizophrenia (a lifelong brain disorder that causes people to interpret reality abnormally), another idiopathic peripheral autonomic neuropathy. During a review of Resident 1's document titled PASRR Level I Screening dated 12/22/22, it indicated a positive result of Level I Screening. There was no documented evidenced the Annual PASRR Screening was completed for 12/2023. Review of the State Agency (SA) letter, dated 12/22/22, revealed the SA was unable to complete a Level II evaluation due to Resident 1 Level II Mental Health Evaluation was not scheduled for the following reason the individual was isolated as a health or safety precaution. The SA letter further revealed as follows: The case is now closed. To reopen, please submit a new Level I Screening. Please note this letter is a courtesy notice for administrative purposes only and does not comprise a completed individualized determination. During a concurrent interview, and record review on 2/15/24 at 9:40 a.m. with Administrator, a letter from Department of Health Care Services dated 12/22/22 indicated Unable to complete Level II Evaluation for Resident 1. It was also indicated After reviewing a Positive Level I Screening and speaking with staff, a Level II Mental Health Evaluation was not scheduled for the following reason: The individual was isolated as a health or safety precaution. The case was now closed. To reopen, please submit a new Level I Screening. The Administrator stated if resident was discharge and comeback from hospital and don't have significant change of condition, it does not need PASRR level I again. During review of facility's policy and procedure (P&P), titled Pre-Admission Screening and Resident Review (PASSR) , dated 12/2017, the P&P indicated, All residents will be screened on admission and annually thereafter

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on observation, interview, and record review, the facility failed to develop and implement individualized, resident-centered a care plans for five of 24 sampled residents (Residents 22, 28, 52, 369, and 79) when: 1. Staff did not follow Resident 22's care plan for wandering (when a person roams around and becomes lost or confused about their location) and elopement (an individual's behavior of leaving an area without permission or supervision); 2. Staff did not develop care plan for Resident 28's diagnosis of chronic obstructive pulmonary disease (COPD, a disease that affects airflow in the lungs and makes it difficult to breathe) and use of oxygen for Resident 28; 3. For Resident 52, there was no care plan developed to address mood disorder (a mental health condition) or skin discoloration; 4. For Resident 369, there was no care plan developed to address chronic obstructive pulmonary disease (COPD, a disease that affects airflow in the lungs and makes it difficult to breathe); and 5. The facility failed to create a care plan for the diagnosis of COPD and use of oxygen for Resident 79. These failures to developed and/or follow care plans had the potential unmet care needs for residents. Findings: 1. Review of Resident 22's face sheet (a document that contains a summary of patient's personal and demographic information) indicated, Resident 22 was admitted to the facility with diagnoses including unspecified dementia (decline in mental capacity affecting daily function), unspecified severity, with agitation (a state of anxiety or nervous excitement), schizoaffective disorder (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania), and bipolar disorder (mental disorder characterized by periods of elevated mood and depression, often with poor decision-making). Review of Resident 22's care plan titled, WANDERING BEHAVIOR, dated 11/21/2023, indicated, At risk for injuries se4condary to wandering behavior .Monitor resident location with visual check at least q (every) 2h (hour). Review of Resident 22's care plan titled, ELOPEMENT, dated November 2023, indicated, At risk for injuries secondary to elopement .Monitor resident location with visual check at least q2h. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an initial observation on 2/12/2024 at 10:44 a.m., Resident 22's bed was empty and unable to locate resident in Hall AA. At 11:15 a.m. Resident 22 was observed outside Hall AA, in front of the facility's exit door and Resident 22 asked every staff that passed by to open the exit door for her. During another observation on 2/13/2024 at 8:38 a.m., Resident 22 was observed in front of the facility's exit door, attempted to open the door, and was not easily redirected. Another observation at 10:18 a.m., Resident 22 was observed at the facility's exit door and asked every staff to open the door for her. During a concurrent interview and record review with licensed vocational nurse F (LVN F) on 2/15/2024 at 9:34 a.m., LVN F reviewed Resident 22's wandering and elopement care plans dated November 2023. LVN F confirmed she couldn't find any documentations about the visual checks as indicated in the care plans. At 11:15 a.m., LVN F showed this surveyor every 15-minute monitoring for Resident 22's whereabouts and confirmed it was initiated when recertification survey started on 2/11/2024. During a concurrent interview and record review with minimum data set coordinator (MDSC) on 2/16/2024 at 11:47 a.m., MDSC confirmed he was not able to find any documentations of staff about every 2-hour visual checks for the month of December 2023 and January 2024. MDSC stated, if there were no documentations in placed, it meant that the visual checks indicated in the care plans were not done. 2. Review of Resident 28's face sheet indicated, Resident 28 was readmitted to the facility on [DATE] with diagnoses including hypertensive heart disease (problems that could develop in the heart as a result of high blood pressure) without heart failure, COPD, and other post procedure complication, and disorders of respiratory system. During an observation on 2/12/2024 at 10:51 a.m., Resident 28 was lying in bed, and was on oxygen at 4 liters per minute (LPM) with the use of nasal cannula (NC, a device used to deliver supplemental oxygen or airflow). During another observation on 2/13/2024 at 2:04 p.m., Resident 28 was lying in bed and was on oxygen at 4 LPM thru NC. During a concurrent interview and record review with licensed vocational nurse T (LVN T) on 2/13/2024 at 2:08 p.m., LVN T reviewed Resident 28's clinical records and confirmed Resident 28 was on oxygen because she had a diagnosis of COPD. During a concurrent interview and record review with LVN F on 2/15/2024 at 9:20 a.m., LVN F reviewed Resident 28's care plans. LVN F confirmed Resident 28 had no care plans developed related to diagnosis of COPD and oxygen use. LVN F stated there should have been care plans developed for Resident 28's COPD diagnosis and oxygen use. Review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, date revised March 2022, indicated, 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS .and no more than 21 days after admission. 44733 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident 52 was admitted on [DATE] with diagnoses including an unspecified mood disorder. During an observation on 2/13/2024 at 10:02 a.m., Resident 52 was observed with multiple bruises on her front side of body (both arm and leg, chest, and abdomen). A review of Resident 52's care plans indicated there was no care plan developed to address mood disorder or skin discoloration. During a concurrent observation and interview on 2/15/2024 at 9:05 a.m. with Licensed Vocational Nurse F (LVN F), Resident 52 was observed with multiple bruises on her left face, both arm, and leg. LVN F confirmed the observation. During a concurrent interview and record review on 2/15/2024 at 9:09 a.m. with LVN F, she reviewed Resident 52's care plans and confirmed there was no care plan developed to address her skin discoloration. LVN F acknowledged that the care plan to address skin discoloration should have been developed for Resident 52. During a concurrent interview and record review on 2/16/2024 at 9:51 a.m. with the Minimum Data Set Coordinator (MDSC), he reviewed Resident 52's clinical record and confirmed Resident 52 had a diagnosis of mood disorder. MDSC confirmed there was no care plan developed to address mood disorder. LVN F acknowledged that the care plan to address mood disorder should have been developed for Resident 52. 4. A review of Resident 369's clinical record indicated she was admitted on [DATE] and had diagnoses including COPD. A review of Resident 369's care plans indicated there was no care plan to address COPD. During a concurrent interview and record review on 2/14/2024 at 1:04 p.m. with Director of Nursing A (DON A), she reviewed Resident 369's care plans and confirmed there was no care plan to address COPD developed. DON A acknowledged that the care plan to address COPD should have been developed for Resident 369. During a review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered, revised 3/2022, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 46939 5. During an observation on 2/13/24, at 9:34 a.m., in Resident 79's room, an oxygen machine was turned on at Resident 79's bedside. Resident 79 was receiving oxygen from the machine via a nasal cannula (plastic tubing that enters the nostrils to supply oxygen). During a review of Resident 79's facesheet, dated 2/16/24, the facesheet indicated, a diagnosis of COPD. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 79's Medical Record (undated), the Medical Record indicated no care plan for the diagnosis of COPD, or for the use of oxygen. During an interview on 2/16/24, at 1:12 p.m., with DON A, DON A stated, if a resident is receiving oxygen they should have a care plan for it. During a review of the facility's P&P titled Care Plans, Comprehensive Person-Centered dated 2016, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on observation, interview and record review, the facility failed to provide an ongoing activity program that meet the resident's needs, interests, and preferences for five of 24 sampled residents when Residents 22, 61, 75, 70, and 41's activity care plan were not updated and followed. This failure had the potential to affect the residents' physical, mental, psychosocial well-being, and self-worth. Findings: 1. Review of Resident 22's face sheet (a document that contains a summary of patient's personal and demographic information) indicated, Resident 22 was admitted to the facility with diagnoses including unspecified dementia (decline in mental capacity affecting daily function), unspecified severity, with agitation (a state of anxiety or nervous excitement), schizoaffective disorder (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania), and bipolar disorder (mental disorder characterized by periods of elevated mood and depression, often with poor decision-making). Review of Resident 22's care plan titled, ACTIVITY/PSYCHOSOCIAL WELL BEING CARE PLAN, dated 11/17/2023, indicated, It is important for resident: To have books, newspaper and Magazines to read; To listen to music; To do things with group of people; To do her favorite Activities; To go outside to get fresh air when weather is good. Further review revealed, the goal was for Resident 22 to participate in programmed activities at least three times a week. The care plan had no other approaches checked except for, Activity staff will monitor resident during activities particularly during arts class and will provide proper make-up kit for residents. During initial observation on 2/12/2024 at 10:44 a.m., Resident 22's bed was empty and unable to locate resident in Hall AA. At 11:15 a.m. Resident 22 was observed outside Hall AA, in front of the facility's exit door and Resident 22 asked every staff that passed by to open the exit door for her. During another observation on 2/13/2024 at 8:38 a.m., Resident 22 was observed in front of the facility's exit door, attempted to open the door, and was not easily redirected. Another observation at 10:18 a.m., Resident 22 was observed at the facility's exit door and asked every staff to open the door for her. During a concurrent observation and interview on 2/14/2024 at 9:52 a.m., Resident 22 was lying in bed, awake and with a certified nurse assistant U (CNA U) as a sitter (a professional who provides supervision and care to residents while in a facility) inside her room. CNA U stated, I am her sitter. I have to watch her. No music or any activities being done. During a concurrent interview and record review with the activities assistant (AA) on 2/15/2024 at 4:30 p.m., AA reviewed Resident 22's activity care plan and their documentations for the month of January and February 2024. AA confirmed January 2024's documentation was activity visits once a week and no activities provided based on Resident 22's interests. AA stated she couldn't find any documentations for the month of February 2024 and confirmed there were no activities provided. (continued on next page)

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	555831	A. Building B. Wing	02/29/2024

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident 61's face sheet indicated, Resident 61 was admitted to the facility with diagnosed including encounter for attention to gastrostomy (a tube inserted through the abdomen that delivers nutrition and medications directly to the stomach or an opening into the stomach from the belly for the introduction of food), cerebrovascular disease (CVA/stroke, a condition resulting from a lack of oxygen in the brain potentially causing a loss of sensory and motor function), paranoid schizophrenia (a pattern of behavior where a person feels distrustful and suspicious of other people and acts accordingly), generalized anxiety (a mental illness that causes constant fear), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and dementia (decline in mental capacity affecting daily function). Review of Resident 61's undated care plan titled, Activity/Psychosocial Well Being Care Plan, indicated, Resident prefers to stay in bed/room .Resident loved: to watch TV; To join others in DR (dining room); T do nail care grooming. Further review revealed, Resident will participate in weekly in room programs; Resident will participate in rooms visits weekly for socialization .active listening when noted feeling anxious, angry & ask what she needed/to meet resident's needs .Offer in room program weekly for mental and social stimulation .Provide resident w/ (with) books/magazine, assist resident w/ music of interest .provide resident w/ outdoor activities . During multiple observations on 2/12, 2/13, 2/14, and 2/15/2024, Resident 61 was observed inside her room, lying in bed and with periods of loud screaming/anger outburst to staff. No activities performed for Resident 61 during the observation days. During a concurrent interview and record review with AA on 2/15/2024 at 4:30 p.m., AA reviewed Resident 61's activity care plan and the documentations they have. AA confirmed they only have activity documentations for Resident 61 on January and February 2023. AA stated they did not have the March 2023 to February 2024 documentations. AA confirmed Resident 61's activity care plan was not implemented. 3. Review of Resident 75's face sheet indicated, Resident 75 was admitted to the facility with diagnoses including type 2 diabetes mellitus (occurs when the body is unable to regulate glucose [sugar] in the blood) with hyperglycemia (elevated blood sugar), dementia with agitation, and hypertensive heart disease (problems that could develop in the heart as a result of high blood pressure) without heart failure. Review of Resident 75's care plan titled, ACTIVITY, dated 6/14/2023, indicated, Provide 1:1 stimulation for resident's most observed responsive senses: touch, smell and sound .Offers religious visits from volunteer . Provide outdoor stimulation .Provide 1:1 program in room and Take resident out of room when up and take to group activities that does not need physical participation. During an initial observation on 2/12/2024 at 10:39 a.m., Resident 75 was lying in bed, asleep. During another observation on 2/13/2024 at 12:29 p.m., resident was in bed and refused to finish her lunch. During a concurrent interview and record review with AA on 2/15/2024 at 4:30 p.m., AA reviewed Resident 75's activity care plan and the documentations they have. AA confirmed they did not have Resident 75's January 2024 activity documentation and for February, she was seen on 2/2, 2/3, 2/9 and 2/11/2024. AA confirmed activities did not happen when there was no documentation. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	44733 4. A review of Resident 70's clinical record indicated she was admitted on [DATE] and had diagnoses including epilepsy (seizure), type 2 diabetes (high blood sugar), major depressive disorder (a mood disorder that causes a feeling of sadness and loss of interest), and bipolar disorder (a mental illness). Her minimum data set (MDS, an assessment tool) dated 12/18/2023 indicated she had a brief interview of mental status (BIMS, a structured cognitive test) scoring 08 (moderate cognitive impairment). During a review of Resident 70's activities care plan, the care plan included interventions to invite/assist to daily activities; offer in room program weekly for mental and social stimulation; and provide resident with books/magazines. During an observation and interview on 2/13/24 at 9:33 a.m., Resident 70 was lying in her bed, and there were no books, newspapers, or magazines for the resident. Resident 70 stated she didn't attend any activities in the facility, and there was no room visit from activity staff. Resident 70 further stated she liked coloring and reading books, but she didn't receive paper to color or a book to read. During an observation from 2/13/2024 to 2/16/2024 in Resident 70's room, there were no books, newspapers, or magazines for the resident observed. During an interview on 2/15/2024 at 1:35 p.m. with the Activities Assistant (AA), she stated Resident 70 has refused to attend the facility's group activities since early 2023. The AA also stated that Resident 70 was offered coloring materials and books. During an interview and record review on 2/15/2024 at 2:05 p.m. with the AA, she reviewed Resident 70's activity care plan and confirmed that Resident 70 should have been invited to activities and provided with coloring material and books. The AA stated she could not locate any documentation indicating the facility offered activities or room visits for Resident 70 from May 2023 to the present. The AA also stated there was no evidence document indicating Resident 70 was offered coloring material or books. The AA acknowledged the activities should have been provided for Resident 70 and documented. 5. A review of Resident 41's clinical record indicated she was admitted on [DATE] and had diagnoses including psychosis (a mental illness), dementia (a decline in mental capacity affecting daily functioning), and hypertension (high blood pressure). Her minimum data set (MDS, an assessment tool) dated 12/18/2023 indicated she had a brief interview of mental status (BIMS, a structured cognitive test) scoring 99 (the resident was unable to complete the interview). During a review of Resident 41's activities care plan, the care plan included interventions to provide 1:1 stimulation to the patient's room when unable to attend activities. During an interview on 2/15/2024 at 1:40 p.m. with the AA, she stated Resident 41 didn't attend the facility group activities and received room visits two to three times a week. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 2/15/2024 at 2:15 p.m. with the AA, she reviewed Resident 41's activity care plan and stated Resident 41 should receive a 1:1 room visit. The AA stated she could not locate any documentation indicating Resident 41 received activities from July 2023 to December 2023. The AA acknowledged the activities should have been provided for Resident 41 and documented. During a review of the facility's policy and procedure (P&P) titled Activity Program, revised 6/2018, the P&P indicated, Activity programs are designed to meet the interests of and support the physical, mental and psychosocial well-being of each resident. Activities offered are based on the comprehensive resident-centered assessment and the preferences of each resident. Activities are scheduled 7 days a week. All activities are documented in the resident's medical record.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27000 Based on observation, interview, and record review, the facility failed to ensure seven of 24 sampled residents (Residents 28, 34, 35, 56, 58, 369 and 370) received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, when: 1. Resident 56's antibiotic order from the hospital was not carried out. This placed the resident at risk for untreated and worsening infection; 2. For Resident 58, the facility staff failed to evaluate and report to the physician when the resident did not sleep for multiple days. The inability to have quality sleep may affect the resident's quality of life and lead to psychosocial outcomes (such as depression, anxiety, distress); 3. For Resident 34 and Resident 35's food tray ticket was not checked during food distribution . 4. For Resident 28, staff administered oxygen without physician's order and staff did not follow the physician's order for the use of Prevalon Boots (type of boots that have a cushioned bottom that floats the heel off the surface of the mattress, helping to reduce pressure); 5. For Resident 369, the facility staff administered oxygen without a physician's order; and 6. For resident 370, the facility staff did not follow their policy and procedure for PICC (peripherally inserted central catheter to deliver medications) line care. These failures had the potential to compromise the resident's health and well-being. Findings: 1. A review of Resident 56's medical record indicated she was admitted to the facility with diagnoses including urinary tract infection (UTI). A review of Resident 56's Minimum Data Set (a resident assessment and screening tool), dated 12/15/23, indicated she had a BIMS score of 15 (Brief Interview for Mental Status, a test given by medical professionals that helps determine a patient's cognitive understanding, scored from 1 to 15), which indicated she was cognitively intact. During an interview with Resident 56 on 2/12/24 at 10:46 a.m., she stated she was transferred to the hospital a few days ago, and was prescribed an antibiotic for UTI but the facility has not given it to her. During another interview with Resident 56 on 2/12/24 at 3:57 p.m., she stated she has been having UTI symptoms such as burning on urination for a week; that was the reason why she went to the hospital. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review with interim Director of Staff Development (IDSD) on 2/12/24 at 3:58 p.m., he reviewed Resident 56's medical record and stated there was a nurses notes on 2/9/24 indicating Resident return to facility 2/9/24 via ambulance . Resident on new orders for Macrobid [an antibiotic for infections] 100 mg [milligrams] twice daily for 5 days. Diagnosis of UTI. He stated, Unfortunately they [the nurses] did not carry out this order. During a follow-up interview with the IDSD on 2/12/24 at 4:35 p.m., he stated he spoke with Resident 56's doctor (Physician) and he prescribed a new antibiotic for her. A review of A review of the acute care hospital's Discharge Summary, dated 2/9/24, indicated Resident 56 was admitted to the hospital on 2/8/24 at 2052 (8:52 p.m.) for UTI, and discharged from the hospital with an for Macrobid 100 mg twice daily for 5 days, from 2/9 to 2/13/24. During a concurrent interview and record review with the Director of Nursing A (DON A) on 2/13/24 at 4:30 p. m., she stated Resident 56 was cared for a registry nurse (licensed or certified staff who receive compensation from a third party agency to work at a nursing care institution). She stated the expectation is that whoever received the resident from the hospital would need to call the physician to carry out the order. She stated the failure to carry out is a medication error and the physician needs to be notified. During an interview with the Physician on 2/15/24 at 9:55 a.m., he acknowledged the nursing staff failed to carry out the Macrobid order for Resident 56. He stated that they should have informed him of the order and carry it out on 2/9/24, the day she returned to the facility. A review of the facility's Acute Condition Changes- Clinical Protocol, dated 3/2018, indicated, The physician and nursing staff will review the details of any recent hospitalization and will identify complications and problems that occurred during the hospital stay . and the nursing staff will collect pertinent details to report to the physician. 2. A review of Resident 58's medical record indicated she was admitted to the facility with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and history of multiple strokes. During an interview with Resident 58 on 2/14/24 at 4:41 p.m., Resident 58 stated she has trouble sleeping and is often unable to sleep through the night. Resident 58 stated she feels exhausted and has not been getting enough sleep for a long time. She stated she would take a short nap in the evening and would stay up all night; when she could not sleep, she would watch TV all night long. Resident 58 verbalized that she is getting trazodone (a medication used for depression and difficulty sleeping) and that it does not work for her sleep. She stated she told someone at the facility last year and no one followed up. A review of the physician's order indicated that Resident 58 gets trazodone 100 milligrams at bedtime for inability to sleep, dated 8/17/23. The physician's order, dated 8/17/23, indicated to monitor number of hours of sleep during evening and overnight shifts. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Resident 58's Physician on 2/15/24 at 9:50 a.m., the Physician stated that Resident 58 or facility staff did not report Resident 58's difficulty sleeping to him. Physician stated he would review the Medication Administration Record (where staff documented the number of hours of sleep) for hours of sleep. A review of Resident 58's electronic medical record indicated that Resident 58 reported to social services (SS) staff on 12/14/23 that she had a few nights where she struggled to fall asleep in the past fourteen days, and that the SS staff informed the nurse of the complaint. During a concurrent interview and record review with Director of Nursing B (DON B) on 2/15/24 at 1:09 p.m., DON B verified that the MAR for Resident 58 showed multiple dates with zero (0) hours of sleep documented for evening and overnight shifts, as follows: - December 2023: 13 out of 31 days had zero hours of sleep - January 2024: 9 out of 31 days days had zero hours of sleep - February 2024: 11 out of 15 days had zero hours of sleep; this indicated Resident 58 only slept 4 nights out of 15 days this month. During this interview and review, DON B stated she was unable to find evidence of the facility staff notifying the physician of her multiple days of unable to sleep, or the follow-up from the SS. DON B stated the physician should have been notified, and staff should have followed up on the SS note from 12/14/23 on Resident 58's lack of sleep. She confirmed that lack of sleep would decrease the resident's quality of life and may lead to distress or behaviors. During an interview with Social Service Director (SSD) on 2/15/24 at 3:17 p.m., she verified that after Resident 58 reported difficulty sleeping on 12/14/23, the SS staff informed Resident 58's nurse and documented in the electronic medical record. The SSD stated she interviewed Resident 58 earlier today and was told the same information she had told the surveyor. A review of the facility's policy and procedures titled Change in a Resident's Condition or Status, revised 2/2021, indicated: Our facility promptly notifies the resident, his or her attending physician . of changes in the resident's medical/mental condition and/or status . The nurse will notify the resident's attending physician . when these has been a . significant change in the resident's physical/mental condition. 46553 3. During a dining observation at Hall BB on 2/12/24 at 12:24 p.m., food tray was served to resident, few of the resident are eating in the dining Hall BB and others resident's respective room. When another HFEN observed Resident 34, and Resident 35's lunch tray was served on time. During review of resident's mealtime: Breakfast 7:15-8:15 a.m., Lunch 12:15-1:15 p.m., and dinner 5:15-6:15 p.m., posted in the dining hall. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 2/12/24 at 1:08 p.m., with Licensed Vocational Nurse P (LVN P), there are two consumed food trays on top of the table outside the dining hall near the food cart for Resident 34 and Resident 35's food tray. LVN P verified above observation those consumed food tray are for Resident 34 and Resident 35. LVN P stated food should have been checked by the nurse and the CNA before serving to resident. During an interview on 2/16/24 at 9:07 a.m., with LVN J, stated nurse check the food tray before distribution to the resident. During an interview on 2/14/24 at 3:47 p.m., with Dietary Manager (DM) stated the food meal including snacks are served in each hall. It was the nurse responsibility to check the food tray. During an interview on 2/15/24 at 3:21 p.m., with master's in science Registered Dietician Nutritionist (MSRDN), stated the nurse pass out the food tray, the staff should check the correct tray to the right resident. MSRDN further stated the nurses takes the tray out in the tray cart and gives the meal based on the meal ticket. During review of facility's policy and procedure (P&P), titled Nourishment Policy , dated 2023, indicated It is the nursing department's responsibility to see that each resident receives the nourishment, as ordered. 44583 4a. Review of Resident 28's face sheet indicated, Resident 28 was readmitted to the facility with diagnoses including hypertensive heart disease without heart failure, chronic obstructive pulmonary disease (COPD - a long lasting lung disease), and other post procedure complication, and disorders of respiratory system. During an observation on 2/12/2024 at 10:51 a.m., Resident 28 was lying in bed, and was on oxygen at 4 liters per minute (LPM) with the use of nasal cannula (NC, a device used to deliver supplemental oxygen or airflow). During another observation 2/13/2024 at 2:04 p.m., Resident 28 was lying in bed and was on oxygen at 4 LPM thru NC. During a concurrent interview and record review with licensed vocational nurse T (LVN T) on 2/13/2024 at 2:08 p.m., LVN T reviewed Resident 28's physician orders and other clinical records. LVN T confirmed Resident 28 had a diagnosis of COPD and there was no physician order for oxygen use. LVN T stated the oxygen rate that Resident 28 had was a high rate and there should be a physician's order for oxygen use. During an interview with LVN F on 2/15/2024 at 9:20 a.m., LVN F stated there should have been a physician's order for oxygen use. 4b. Review of Resident 28's clinical records titled, Physician Orders, dated February 2024, indicated, BILATERAL (both) FEET - APPLY PREVALON BOOT Q (every) SHIFT (days, evenings, nights) WHILE IN BED, date ordered 1/12/2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 2/13/2024 at 2:04 p.m., Resident 28 was lying in bed, wearing one Prevalon Boot to her right foot. There was no boot on her left foot. During a concurrent interview and record review with LVN T on 2/13/2024 at 2:08 p.m., LVN T reviewed the physician's order for Prevalon Boot use. LVN T confirmed Resident 28 should have Prevalon boots to both feet while in bed. LVN T further confirmed she only found one Prevalon boot and would look for one more. During an interview with LVN F on 2/15/2024 at 9:27 a.m., LVN F stated, as a nurse, we should follow the physician's order. 44733 5. A review of Resident 369's clinical record indicated she was admitted on [DATE] and had diagnoses including chronic obstructive pulmonary disease (COPD, a disease that affects airflow in the lungs and makes it difficult to breathe). During an observation on 2/12/2024 at 9:55 a.m., Resident 369 was lying in bed receiving oxygen at 2.5 liters/min (liters per minute, LPM, unit of measurement) via nasal cannula (flexible tubing placed into the nostrils and connected to an oxygen source). During an interview and record review on 2/12/2024 at 10:36 a.m. with Registered Nurse L, she confirmed the observation. RN L reviewed Resident 369's physician's order and confirmed there was no physician order to apply oxygen to Resident 369. RN L acknowledged that a licensed nurse should have obtained a physician order for oxygen prior to applying the oxygen. During an interview on 2/14/2024 at 1:03 p.m. with Director of Nursing A (DON A), she acknowledged there should have been a physician's order to apply oxygen to the residents. During a review of the facility's policy and procedure (P&P) titled Oxygen Administration, revised 10/2010, the P&P indicated, Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 6. During an observation on 2/13/2024 at 9:01 a.m., Resident 370 was lying in bed, and a PICC line on his right arm was observed. A review of Resident 370's clinical record indicated he had a physician's order, dated 1/09/2024, for a right upper arm PICC line-change dressing every 7 days every Monday using sterile technique. A review of Resident 370's February 2024 TAR indicated there was no documentation of the dressing change for the right upper arm PICC line on Monday, 2/12/2024. A review of Resident 370's clinical record indicated there was no documentation indicating the arm circumference and length of the external catheter were measured during the dressing change for the PICC on the right upper arm. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/14/2024 at 1:15 p.m. with Director of Nursing A (DON A), she stated the PICC line dressing should have been changed weekly and the arm circumference and the length of the external catheter should have been measured during the dressing change to confirm the placement of the PICC line and documented. During an interview and concurrent record review on 2/15/2024 at 1:00 p.m. with Licensed Vocational Nurse F (LVN F), she confirmed Resident 370's February 2024 TAR, which indicated there was no documentation of the dressing change for the right upper arm PICC line on 2/12/2024. LVN F also confirmed there was no evidenced documentation indicating the arm circumference and the length of the external catheter were measured during the dressing change to confirm the placement of the PICC line. During a review of the facility's policy and procedure (P&P) titled PICC Dressing Change, dated 6/2018, the P&P indicated, Dressing changes using transparent dressings are performed: 2. At least weekly. Length of external catheter is obtained: 2. During dressing changes. Documentation in the medical record includes, but is not limited to: 2. Site assessment; 3. Length of external catheter.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 27000 Based on observation, interview, and record review, the facility failed to ensure the environment was safe and free of accident hazards for two of 97 residents in the facility (Residents 40 and 81). Resident 81's broken pieces of glass from the wall clock in his room were not cleaned up timely, posing a risk of injury for the residents and staff. For Resident 40, the facility staff placed a wet shower sheet blanket on the floor near the bed, presenting a fall risk for the resident. Findings: 1. During the medication administration observation with Licensed Vocational Nurse (LVN) C and LVN D on 2/12/24 at 9:09 a.m., eight pieces of sharp, broken glass, in various sizes, were observed on the floor, near Resident 81's bed and wheelchair. Both nursing staff acknowledged this observation. LVN D stated the glass wall clock fell off the wall last night, and the night shift staff must have missed it when they did the cleaning. During an interview with LVN D on 2/12/24 at 9:18 a.m., LVN D stated the wall clock broke around 4 a.m. (five hours ago). She explained that Resident 81 was asking for help, when the nurse arrived he was getting agitated. She stated she worked the night shift last night and should have made sure it was cleaned up right. She acknowledged the broken glasses presented a risk of injury to the resident. A review of Resident 81's medical record indicated he was admitted to the facility with diagnoses including cognitive communication defect deficit, mild neurocognitive (related to ability to think and reason) disorder due to known physiological conditions without behavioral disturbance, history of traumatic brain injury, and falling. A review of Resident 81's Minimum Data Set (a resident assessment and screening tool), dated 1/5/24, indicated he had a BIMS score of 9 (Brief Interview for Mental Status, a test given by medical professionals that helps determine a patient's cognitive understanding, scored from 1 to 15), which indicated he had moderate cognitive impairment. During an interview with Director of Nursing A (DON A) on 2/13/24 at 4:49 p.m., she stated the broken glasses observed in Resident 81's room should have been cleaned up right away for the safety of residents and staff. 46939 2. During an observation on 2/12/24, at 9:07 a.m., in Resident 40's room, a folded sheet was noted on the floor to the right side of Resident 40s bed, spanning the length of the whole bed. The sheet was noted to be wet in the middle. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/12/24 at 9:24 a.m., with certified nursing assistant (CNA) Q, CNA Q stated, she folded the sheet and placed it on the floor next to Resident 40's bed this morning when she started her shift. CNA Q stated, Resident 40 urinates on the floor, so we lay out a sheet on the floor to soak it up, the other CNAs told me to do this, we have always done this as far as I could remember. CNA Q stated, Resident 40 was a high risk for fall, so I could see how the sheet would have been an issue related to fall and I would remove it now. During an observation on 2/13/24, at 9:29 a.m., in Resident 40's room, a sheet was seen folded on the floor spanning the right-side length of the bed. During an interview on 2/13/24, at 9:32 a.m., with CNA K, CNA K stated, she folded the sheet and placed it on the floor. During a review of Resident 40's Fall Risk Care Plan dated 7/29/23, Care plan indicated, at risk for fall rt [related to] dx [diagnosis] of dementia. Maintain safe environment, room free of clutter. A review of the facility's policy and procedures titled Safety and Supervision of Residents, dated 7/2017, indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on observation, interview, and record review, the facility failed to ensure that proper care and treatment services for oxygen (O2) was provided for five of nine sampled residents (Resident 61, 28, 58, 369, and 1) when: 1. Staff did not follow the physician's order for Resident 61's oxygen therapy; 2. Staff did not post an Oxygen in use/No Smoking sign at Resident 28's door; 3. Staff did not post an Oxygen in use/No Smoking sign at Resident 58's door. 4. Staff did not post an Oxygen in use/No Smoking sign at Resident 369's door; and 5. Licensed vocational nurse (LVN) J failed to ensure oxygen (a colorless and odorless gas that people need to breath) was administered as specified in the physician's order and the nasal cannula (NC, flexible tubing inserted into the nostrils and attached to an oxygen source) was outdated for Resident 1; and These failures had the potential to result in complications related to improper treatment while receiving O2 therapy. Findings: 1. Review of Resident 61's face sheet indicated, Resident 61 was admitted to the facility with diagnoses including encounter for attention to gastrostomy (a tube inserted through the abdomen that delivers nutrition and medications directly to the stomach or an opening into the stomach from the belly for the introduction of food), cerebrovascular disease (CVA/stroke, a condition resulting from a lack of oxygen in the brain potentially causing a loss of sensory and motor function), paranoid schizophrenia (a pattern of behavior where a person feels distrustful and suspicious of other people and acts accordingly), generalized anxiety (a mental illness that causes constant fear), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and dementia (decline in mental capacity affecting daily function). Review of Resident 61's Physician Orders for the month of February 2024, indicated an order on 11/28/23, MAY ADMINISTER OXYGEN VIA (thru) NASAL CANNULA (NC) UP TO 5 LPM (liters per minute) AS NEEDED FOR SOB (shortness of breath). During an observation on 2/12/2024 at 10:19 a.m., Resident 61 was in bed, and was on oxygen therapy at 3 LPM via NC. During a concurrent interview and record review with licensed vocational nurse T (LVN T) on 2/13/2024 at 2:16 p.m., LVN T reviewed Resident 61's physician orders. LVN T confirmed Resident 61's oxygen order was at 5 LPM as needed for SOB. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During another observation on 2/14/2024 at 9:43 a.m., Resident 61 was lying in bed and oxygen was in placed at 6 LPM via NC. During a concurrent interview and record review with licensed vocational nurse F (LVN F) on 2/15/2024 at 9:12 a.m., LVN F reviewed Resident 61's physician orders and the photo taken on 2/14/2024 at 9:43 a.m. with the oxygen's rate level. LVN F confirmed the order for Resident 61's oxygen rate was 5 LPM as needed for SOB. LVN F further confirmed the photo of the oxygen level was passed the 5 LPM. LVN F stated nurses should have follow the doctor's order for oxygen administration. During a review of the facility's policy and procedure titled, Oxygen Administration, date revised October 2010, indicated, The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation: 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review of Resident 28's face sheet indicated, Resident 28 was readmitted to the facility on [DATE] with diagnoses including hypertensive heart disease without heart failure (problems that could develop in the heart as a result of high blood pressure), chronic obstructive pulmonary disease (COPD, a disease that affects airflow in the lungs and makes it difficult to breathe), and other post procedure complication, and disorders of respiratory system. During an initial observation on 2/12/2024 at 10:51 a.m., Resident 28 was observed with oxygen in used at 4 LPM via NC. There was no Oxygen in use/No Smoking, sign posted at Resident 28's entrance door. During a concurrent observation and interview with registered nurse L (RN L) on 2/12/2024 at 11:05 a.m., RN L confirmed there was no signage regarding the use of oxygen in Resident 28's entrance door. RN L stated they run out of the Oxygen in use /No Smoking sign. During an interview with LVN F on 2/15/2024 at 9:20 a.m., LVN F stated the Oxygen in use/No Smoking sign should have been posted at the entrance door of Resident 28. LVN F confirmed they have some smokers in Hall AA. 3. Review of Resident 58's face sheet indicated, Resident 58 was admitted to the facility with diagnoses including hypertensive heart disease without heart failure, acute respiratory failure (a condition when lungs cannot release oxygen to blood causing shortness of breath) and vascular dementia (problems with reasoning, planning, judgement, memory, and other thought processes caused by brain damage from impaired blood flow to the brain). During an observation on 02/12/24 at 09:25 AM in Hall CC, Resident 58 was observed receiving oxygen via nasal cannula with the oxygen concentrator at the bedside with no sign of Oxygen in use/No Smoking posted by the door outside Resident 58's room. During an interview with certified nurse assistant Y (CNA Y), on 02/12/24 at 09:27 AM, CNA Y confirmed, there was no sign on Resident 58's door because Resident 58 doesn't receive oxygen all the time. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure title, Oxygen Administration, date revised October 2010, indicated, Steps in the Procedure: .2. Plan an Oxygen in Use sign on the outside of the room entrrance door . 44733 4. A review of Resident 369's clinical record indicated she was admitted on [DATE] and had diagnoses including chronic obstructive pulmonary disease (COPD, a disease that affects airflow in the lungs and makes it difficult to breathe). During an observation on 2/12/2024 at 9:55 a.m., Resident 369 was lying in bed receiving oxygen at 2.5 liters/min (liters per minute, LPM, unit of measurement) via nasal cannula (flexible tubing placed into the nostrils and connected to an oxygen source). There was no signage for the oxygen posted outside of the room. During an interview and record review on 2/12/2024 at 10:36 a.m. with Registered Nurse L, she confirmed the observation. RN L acknowledged the signage for the oxygen should have been posted outside of the room because Resident 369 was in use of the oxygen. During a review of the facility's policy and procedure (P&P) titled Oxygen Administration, revised 10/2010, the P&P indicated, The following equipment and supplies will be necessary when performing this procedure. 4. No Smoking/Oxygen in Use signs. 46553 5. Review of Resident 1's clinical record indicated he was readmitted on [DATE] and had a diagnosis of dysphagia (difficulty swallowing), asthma (a condition a person 's airway become inflamed, narrow, and swell), cognitive communication deficit (difficulty with thinking and how someone uses language), seizure (a sudden, uncontrolled burst of electrical activity in the brain). Review of Resident 1's Physician Orders dated 12/22/23, indicated, may administer oxygen two to four liters per minute (LPM, rate of oxygen administration) via NC as needed to maintain oxygen level above 93% .) and change oxygen tubing and humidifier (a device to increase the moisture level in the air) every Sunday. During an observation on 2/12/24 at 9:13 a.m., Resident 1's oxygen concentrator (machine used to deliver oxygen) was set at 4.5 LPM and receiving oxygen via NC. The NC was dated 2/4/24 (8 days prior to this observation). During a concurrent observation and interview on 2/12/24 at 9:40 a.m., with the License Vocational Nurse C (LVN), stated Resident 1's oxygen order was 2-4 L. She further stated NC should had been changed yesterday, Sunday. It's a weekly change of NC. During an observation on 2/13/24 at 8:00 a.m., Resident 1's oxygen concentrator was set at 4.5 LPM and receiving oxygen via NC. The NC was dated 2/12/24 (1 days prior to this observation). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 2/13/24 at 8:02 a.m., with LVN J, she confirmed the oxygen was on 4.5 lpm via NC. LVN J verified the Resident 1's NC was dated 2/12/24. She stated the NC are change every week. During a concurrent interview and record review on 2/13/24 at 9:46 a.m., with LVN J, she checks the physician order and stated the oxygen order for Resident 1's was 2-4 L. During an interview on 2/16/24 at 1:11 p.m., with Director of Nursing A (DON A), she stated oxygen are based on the physician order and should follow the order.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44733 Based on observation, interview, and record review, the facility failed to provide adequate pain management in accordance with physician orders and resident needs for one of 24 sampled residents (Resident 370). This failure could result in ineffective pain management. Findings: A review of Resident 370's clinical record indicated he was admitted on [DATE] and had diagnoses including acute osteomyelitis (inflammation of bone caused by infection), type 2 diabetes (high blood sugar) with diabetic neuropathy (a nerve damage that occurs with diabetes), and bipolar disorder (a mental health disorder). His minimum data set (MDS, an assessment tool) dated 1/11/2024 indicated he had a brief interview of mental status (BIMS, a structured cognitive test) scoring 15 (cognitively intact). During an interview on 2/13/2024 at 9:50 a.m. with Resident 370, he stated he didn't receive his Norco (a pain medication) to control his pain on his feet for a week. Resident 370 also stated that the nurse told him that they had no Norco available when he requested it and gave him Tylenol, which was not enough to alleviate his pain. Resident 370 further stated he was having pain with a pain scale of 10/10 (meaning severe pain) on his feet now and wanted to take Norco for his pain. A review of Resident 370's medical record indicated a physician order dated 1/09/2024 indicated Monitor pain level every shift: 0=no pain, 1-3=mild pain, 4-7=moderate pain, 8-10=very severe pain; a physician order dated 1/08/2024 indicated Hydromorphone 2 mg (milligrams) tablet, give 1 tablet by mouth every 3 hours as needed for moderate to severe pain; a physician order dated 1/10/2024 indicated Norco 5-325 tablet, take 1 tablet by mouth every 4 hours as needed for moderate to severe pain A record review of Resident 370's medication administration record (MAR) for February 2024 on 2/13/2024 indicated Resident 370's pain level was 5 on 2/09/2024 and 2/11/2024; 6 on 2/05/2024; and 7 on 2/02/2024, 2/03/2024, and 2/07/2024. The MAR also reflected that there was no Norco administration from 2/02/2024 to 2/13/24. During an interview and record review on 2/13/2024 at 10:22 a.m. with Licensed Vocational Nurse T (LVN T), she stated that Resident 370 requested the Norco, but she does not have the Norco or Hydromorphone to give to Resident 370 because it was not available to administer. LVN T stated she called the facility pharmacy, and the pharmacy staff informed her that the physician needed to sign for the prescription. During a concurrent interview and record review on 2/14/2024 at 1:09 p.m. with Director of Nursing A (DON A), she confirmed Resident 370 had a physician's order of Norco for moderate to severe pain as needed, and the Norco was not available to administer for Resident 370 from 2/02/2024 to 2/13/2024. DON A acknowledged that Norco should have been available to administer upon request for Resident 370 to manage his moderate to severe pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/14/2024 at 1:12 p.m. with DON A, she confirmed Resident 370's pain assessment indicated he had moderate to severe pain on 2/02/2024, 2/03/2024, 2/05/2024, 2/07/2024, 2/09/2024, and 2/11/2024. DON A acknowledged that Norco should have been administered upon request for moderate to severe pain as ordered. During a review of the facility's policy and procedures (P&P) titled Pain Assessment and Management, revised 10/2022, The pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. Pain management is defined as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals. The medication regimen is implemented as ordered.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on observation, interview, and record review, the facility failed to ensure the proper use of side or bed rails (adjustable rigid bars attached to the side of a bed) for 40 (Residents 3, 6, 8, 10, 12, 14, 18, 20, 22, 24, 27, 28, 32, 41, 42, 45, 49, 50, 52, 55, 56, 58, 59, 64, 67, 69, 70, 74, 78, 91, 96, 98, 100, 103, 105, 113, 319, 320, 321, and 369) of 40 sampled residents (residents who used bed or side rails) when: 1. There was no documentation that indicated the facility conducted consistent routine maintenance of the facility's beds and side rails for 40 of 40 sampled residents; 2. There was no documentation of informed consents (A process in which patients are given important information, including possible risks and benefits, about a medical procedure or treatment) were obtained prior to bed rail use for 40 of 40 sampled residents; 3. There was no documentation that indicated alternatives were offered and/or attempted prior to the use of side rails for 38 of 40 sampled residents (Residents 3, 6, 10, 12, 14, 18, 20, 22, 24, 27, 28, 32, 41, 42, 45, 49, 50, 52, 55, 56, 58, 59, 64, 67, 69, 70, 74, 78, 91, 96, 98, 100, 103, 105, 113, 319, 321 and 320); 4. There was no side rail assessment form completed prior to the use of side rails for 16 of 40 sampled residents (Residents 6, 22, 24, 27, 64, 319, 320, 321, 20, 42, 45, 56, 58, 59, 98 and100); and 5. There were no side rail care plans for 29 of 40 sampled residents (Residents 3, 8, 10, 14, 18, 20, 22, 27, 28, 41, 49, 52, 56, 58, 64, 69, 70, 74, 78, 91, 96, 98, 100, 103, 105,113, 320, 321, and 369). These failures had the potential to place the residents at risk of entrapment and serious injury. Findings: 1. During an interview with Maintenance Director (MD) on 2/14/2024 at 10:46 a.m., MD stated maintenance would install bed rails to resident's bed when ordered by nurses. MD confirmed there was no daily bed rail checks or annual checks of the beds unless there was a complain about it. MD further confirmed there was no daily routine checks of the bed. MD stated if the bed was broken staff would write it in the maintenance log. During a review of the facility's policy and procedure titled, Bed Safety and Bed Rails, date revised August 2022, indicated, Maintenance staff routinely inspects all beds and related equipment to identify risks and problems including potential entrapment risks. 2. During an observation in Resident 69's room on 2/12/2024 at 9:00 a.m ., Resident 69 had bilateral (both sides) half side rails in his bed and were raised up. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation in Resident 55's room on 2/12/2024 at 9:01 a.m ., Resident 55 had bilateral half side rails in his bed and were raised up. During an observation in Resident 96's room on 2/12/2024 at 9:17 a.m ., Resident 96 had bilateral half side rails in his bed and were raised up. During an observation in Resident 10's room on 2/12/2024 at 9:18 a.m ., Resident 10 had bilateral half side rails in his bed and were raised up. During an observation in Resident 91's room on 2/12/2024 at 9:25 a.m., Resident 91 had bilateral half side rails in his bed and in upright position. During an observation in Resident 3's room on 2/12/2024 at 9:41 a.m., Resident 3 had bilateral half side rails in bed and in upright position. During an observation in Resident 321's room on 2/12/2024 at 11:08 a.m., Resident 321 was lying in bed, with right side rail raised up and the left side of the bed was against the wall. During an observation in Resident 98's room on 2/14/2024 at 10:28 a.m., Resident 98 had bilateral bedrails in the upright position. During an observation in Resident 56's room on 2/14/24 at 10:28 a.m., Resident 56 was awake and seated up in bed with bilateral upper bedrails in upright position. During an observation in Resident 59's room on 2/14/24 at 10:30 a.m., Resident 59 was lying in bed with bilateral upper bedrails in the upright position. During a concurrent observation and interview with Resident 42 on 2/14/24 at 10:31 a.m., Resident 42 was observed walking around the room, one right side bedrail was in upright position, and the left side of bed was pushed against the wall. Resident 42 stated she used right sided bedrail to assist her with standing. During an observation on 2/14/24 at 10:33 a.m., Resident 100 was lying in bed with right sided bedrail in upright position and the left side of bed was pushed against the wall. Across Resident 100's room was Resident 58's room, Resident 58 was observed seated at the edge of bed and had bilateral upper bedrails in upright position. During an interview with medical record director (MRD) on 2/14/2024 at 10:35 a.m., MRD stated side rail consent should be found in resident's chart under the consent tab. MRD confirmed she did not file any side rail consent since she started working at the facility 14 months ago. At 10:50 a.m., after looking at resident's filed charts, MRD confirmed Residents 3, 6, 8, 10, 12, 14, 18, 20, 22, 24, 27, 28, 32, 41, 42, 45, 49, 50, 52, 55, 56, 58, 59, 64, 67, 69, 70, 74, 78, 91, 96, 98, 100, 103, 105, 113, 319, 320, 321, and 369 did not have consents for bed/side rail use. During an observation in Resident 50's room on 2/14/24 at 10:40 a.m., Resident 50 was lying in bed with bilateral upper bedrails in upright position. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation in Resident 20's room on 2/14/24 at 10:42 a.m., Resident 20 was awake, seated up in bed with bilateral upper bedrails in upright position. During an observation in Resident 45's room on 2/14/24 at 10:45 a.m., Resident 45 was lying in bed, with bilateral upper bedrails in upright position. During a concurrent observation and interview on 2/14/23, at 12:31 p.m., with licensed vocational nurse D (LVN D), in Resident 67's room, two upper side rails were in upright position on Resident 67's bed. LVN D confirmed, Resident 67 had two upper side rails in bed. During a review of Resident 67's Medical Record (undated), the Medical Record indicated, no consent was documented for use of side rails. During a concurrent observation and interview on 2/14/23, at 12:33 p.m., with LVN D, in Resident 78's room, two upper side rails were in upright position on Resident 78's bed. LVN D confirmed the observation. During a review of Resident 78's Medical Record (undated), the Medical Record indicated, no consent was documented for use of side rails. During a concurrent observation and interview on 2/14/23, at 12:38 p.m., with LVN D, in Resident 49's room, two upper side rails were in upright position on Resident 49's bed. LVN D confirmed Resident 49 had two upper side rails in bed. During a review of Resident 49's Medical Record (undated), the Medical Record indicated, no consent was documented for use of side rails. During a concurrent observation and interview on 2/16/23 at 8:48 a.m. with LVN F in Resident 52's room, two upper side rails were in upright position on Resident 52's bed. LVN F confirmed the observation. During a concurrent observation and interview on 2/16/23 at 8:50 a.m. with LVN F in Resident 369's room, two upper side rails were in upright position on Resident 369's bed. LVN F confirmed the observation. During a concurrent observation and interview on 2/16/23 at 8:52 a.m. with LVN F in Resident 70's room, two upper side rails were in upright position on Resident 70's bed. LVN F confirmed the observation. During a concurrent observation and interview on 2/16/23 at 8:53 a.m. with LVN F in Resident 41's room, two upper side rails were in upright position on Resident 41's bed. LVN F confirmed the observation. During a concurrent observation and interview on 2/16/23 at 8:54 a.m. with LVN F in Resident 103's room, two upper side rails were in upright position on Resident 103's bed. LVN F confirmed the observation. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview on 2/16/23 at 8:55 a.m. with LVN F in Resident 105's room, two upper side rails were in upright position onn Resident 105's bed. LVN F confirmed the observation. During a concurrent observation and interview on 2/16/23 at 8:56 a.m. with licensed vocational nurse F (LVN F) in Resident 8's room, one upper side rail was raised up on Resident 8's bed. LVN F confirmed the observation. During an interview with licensed vocational nurse C (LVN C) on 2/16/24 at 8:58 a.m., LVN C confirmed the beds of Residents 3, 10, 55, 69, 91, and 96 had side rails. During a concurrent observation and interview with LVN F on 2/16/2024 at 9:00 a.m., in Residents 319 and 32's room, two upper bed rails were raised up on Resident 319's bed. LVN F confirmed Resident 319 used her bed rails for turning and to sit up at the edge of the bed. Residents 319 and 32 were roommates. Resident 32's two upper side rails were in upright position on Resident 32's bed. LVN F confirmed the observation. During a concurrent observation and interview on 2/16/23 at 9:01 a.m. with LVN F in Residents 113 and 12's room, two upper side rails were raised up on Resident 113's bed. Resident 12 who was Resident 113's roommate had a bed with two upper bed rails in upright position. LVN F confirmed both observations. During a concurrent observation and interview with LVN F on 2/16/2024 at 9:02 a.m., in Resident 320's room, two upper bed rails were raised up. LVN F confirmed Resident 320 used his bed rails to assist with repositioning. During a concurrent observation and interview on 2/16/23 at 9:03 a.m. with LVN F in Resident 18's room, two upper side rails were in upright position on Resident 18's bed. LVN F confirmed the observation. During a concurrent observation and interview on 2/16/23 at 9:04 a.m. with LVN F in Resident 14's room, two upper side rails were in upright position on Resident 14's bed. LVN F confirmed the observation. During a concurrent observation and interview with LVN F on 2/16/2024 at 9:05 a.m., in Residents 27 and 6's room, two upper bed rails were raised up on Resident 27's bed. LVN F confirmed Resident 27 used the two upper bed rails to help with turning. Resident 6 who was Resident 27's roommate had a bed with two upper bed rails in upright position. LVN F confirmed Resident 6 used her bed rails for turning and to helped her to sit up at the edge of bed. During a concurrent observation and interview with LVN F on 2/16/2024 at 9:06 a.m., in Residents 24 and 64's room, right bed rail was raised up on Resident 24's bed. LVN F confirmed Resident 24 used one bed rail to assist with turning. Resident 64 who was Resident 24's roommate had a bed with two upper bed rails raised up. LVN F confirmed Resident 64 held on to the bed rail whenever certified nurse assistants (CNAs) would turn her. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview with LVN F on 2/16/2024 at 9:08 a.m., in Residents 28 and 74's room, left upper bed rail was raised up on Resident 28's bed and right side of the bed was against the wall. LVN F confirmed Resident 28 used the left upper bed rail to help her turn. Resident 74 who was Resident 28's roommate had a bed with right upper bed rail in upright position. LVN F confirmed Resident 74 used her bed rail to help with turning. During a concurrent observation and interview with LVN F on 2/16/2024 at 9:10 a.m., in Resident 22's room, left bed rail was in upright position on Resident 22's bed. LVN F confirmed Resident 22 used the left bed rail for repositioning and she held on to it to sit up at the edge of bed. Review of Residents 3, 8, 10, 12, 14, 18, 20, 32, 41, 42, 45, 49, 50, 52, 55, 56, 58, 59, 67, 69, 70, 78, 91, 96, 98, 100, 103, 105, 113, 319, 320, 321, 369, 27, 6, 24, 64, 28, 74, and 22' s clinical records, indicated no bed rail or side rail consents were obtained prior to use of bed rails. During a review of the facility's policy and procedure titled, Bed Safety and Bed Rails, date revised August 2022, indicated, 8. Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent. 3. During a review of Resident 67's Side Rail Assessment, dated 1/22/24, Assessment indicated, no documented use of alternatives prior to using side rails. During a review of Resident 78's Side Rail Assessment, dated 10/2/22, Assessment indicated, no documented use of alternatives prior to using side rails. During a review of Resident 49's Side Rail Assessment, dated 12/8/22, Assessment indicated, no documented use of alternatives prior to using side rails. Review of Residents 319, 320 ,321, 27, 6, 24, 64, 28, 74, and 22's charts revealed there were no Bedrail assessments completed and there were no alternatives offered or attempted prior to use of bed rails/side rails. During an interview with minimum data set coordinator (MDSC) on 2/15/2024 at 11:56 a.m., MDSC confirmed there were no alternatives offered or attempted to 38 of 40 residents (Residents 3, 6, 10, 12, 14, 18, 20, 22, 24, 27, 28, 32, 41, 42, 45, 49, 50, 52, 55, 56, 58, 59, 64, 67, 69, 70, 74, 78, 91, 96, 98, 100, 103, 105, 113, 319, 321 and 320) prior to side/bed rail use d. During a concurrent interview and record review with MDSC on 2/16/2024 at 9:37 a.m., MDSC reviewed Resident 28 and 74's clinical records. MDSC confirmed Residents 28 and 74 had Bedside Rail Assessment done. MDSC confirmed Resident 28's Bedside Rail Assessment completed on 1/16/2024 revealed, there were no alternatives offered prior to use of bed rails. MDSC confirmed Resident 74's Bedside Rail Assessment initiated on 1/26/2024 did not indicate alternatives were tried prior to bedside rail used. During a review of Resident 12's Side Rail Assessment, dated 7/13/2022, Assessment indicated, no documented use of alternatives prior to using side rails. During a review of Resident 14's Side Rail Assessment, dated 6/27/2023, Assessment indicated, no documented use of alternatives prior to using side rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 18's Side Rail Assessment, dated 7/15/2022, Assessment indicated, no documented use of alternatives prior to using side rails. During a review of Resident 32's Side Rail Assessment, dated 1/23/2023, Assessment indicated, no documented use of alternatives prior to using side rails. During a review of Resident 41's Side Rail Assessment, dated 9/01/2022, Assessment indicated, no documented use of alternatives prior to using side rails. During a review of Resident 52's Side Rail Assessment, dated 1/22/2024, Assessment indicated, no documented use of alternatives prior to using side rails. During a review of Resident 70's Side Rail Assessment, dated 9/19/2022, Assessment indicated, no documented use of alternatives prior to using side rails. During a review of Resident 103's Side Rail Assessment, dated 9/09/2023, Assessment indicated, no documented use of alternatives prior to using side rails. During a review of Resident 105's Side Rail Assessment, dated 9/23/2023, Assessment indicated, no documented use of alternatives prior to using side rails. During a review of Resident 113's Side Rail Assessment, dated 1/03/2024, Assessment indicated, no documented use of alternatives prior to using side rails. During a review of Resident 3's Side Rail Assessment , dated 10/9/23, Assessment indicated, no documented use of alternatives prior to using side rails. During a review of Resident 10's Side Rail Assessment , dated 10/4/23, Assessment indicated, no documented use of alternatives prior to using side rails. During a review of Resident 55's Side Rail Assessment , dated 9/12/22, Assessment indicated, no documented use of alternatives prior to using side rails. During a review of Resident 69's Side Rail Assessment , dated 3/22/23, Assessment indicated, no documented use of alternatives prior to using side rails. During a review of Resident 91's Side Rail Assessment , dated 6/6/23, Assessment indicated, no documented use of alternatives prior to using side rails. During a review of Resident 96's Side Rail Assessment , dated 9/22/23, Assessment indicated, no documented use of alternatives prior to using side rails. Review of Residents 20, 42, 45, 56, 58, 59, 98 and 100's charts revealed there were no Bed rail assessments completed and no alternatives offered or attempted prior to use of bed rails. Review of Resident 50's bedside rail assessment form, dated 1/22/2024, indicated there were no alternatives offered or attempted prior to use of bed rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's policy and procedure titled, Bed Safety and Bed Rails, date revised August 2022, indicated, 4. Prior to the installation or use of a side or bed rail, alternatives to the use of side or bed rails are attempted .5. If attempted alternatives do not adequately [NAME] t the resident's needs the resident may be evaluated for the use of bed rails . 4. During a concurrent interview and record review with MDSC on 2/16/2024 at 9:33 a.m., MDSC reviewed Residents 6, 22, 24, 27, 64, 319, 320 and 321's clinical records. MDSC confirmed there were no initiated or completed Bedside Rail Assessments for Residents 6, 22, 24, 27, 64, 319, 320, and 321. MDSC stated there should be a bed rail/side rail assessment done prior to use of bed rails to determine if it was appropriate for residents' use. Review of Residents 20, 42, 45, 56, 58, 59, 98 and 100's clinical records revealed there were no documented bedrail assessment forms initiated or completed. During a review of the facility's policy and procedure titled, Bed Safety and Bed Rails, date revised August 2022, indicated, 3. The use of bed rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. 5. Review of the 40 sampled resident's Bed/Side rail care plans, revealed 29 of 40 sampled residents (Residents 3, 8, 10, 14, 18, 20, 22, 27, 28, 41, 49, 52, 56, 58, 64, 69, 70, 74, 78, 91, 96, 98, 100, 103, 105, 113, 320, 321, and 369) did not have bed or side rails care plan. During an interview with registered nurse L (RN L) on 2/29/2024 at 10:21 a.m., RN L stated residents who had bed rails in used should have a care plan in place. RN L further stated care plans were important for nurses to know the proper implementation or intervention needed by the residents and for nurses to revise the care plan if the interventions did not work. During an interview with MDSC on 2/29/2024 at 10:54 a.m., MDSC stated there should be a care plan for bed rail used. MDSC further stated, bed rail care plans were important for nurses to visualize the need of each resident.

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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. 46939 Based on interview and record review, the facility failed to ensure nursing staff were competent in the use of the facility's charting system prior to their first shift. This failure had the potential for incorrect documentation of patient care, assessments, and medication administration. Findings: During an interview on 2/15/24, at 12:46 p.m., with the Interim Director of Staffing Development (IDSD), IDSD stated, he took over this position on 2/8/24. IDSD stated, he was not able to locate the onboarding binder which oriented new staff to the charting system. IDSD stated, our charting system was not as common as other Long Term Care Facilities so with the prior DSD, staff were trained on how to use the software prior to starting work. IDSD stated, we recently lost over 10 Licensed Nurses in the past two weeks so we utilize registry staff from three different companies. IDSD stated, I do not have any documentation showing that the registry staff were oriented or competent in use of our charting system prior to starting work. IDSD stated, currently we are relying on other staff who have been here longer to help teach the new registry staff how to use the charting system. During an interview on 2/15/24 at 1:09 p.m., with Licensed Vocational Nurse (LVN) F, LVN F stated, I only got a vague intro to the facility when I started two weeks ago. I did not have any onboarding training regarding using the charting system. I had to rely on other nurses or certified nurse assistants (CNAs) to help me with charting while I worked. During an interview on 2/15/24 at 10:35 a.m., with CNA K, CNA K stated They did not train me on how to chart, I had to learn as I worked. CNA K stated, she started working at the facility October 2023, the charting system was hard to use so it took me a while to learn, a lot of people complain about it. During an interview on 02/15/24, at 4:18 p.m., with IDSD, IDSD stated, there is no documentation in the employee files about training or competency for the charting system. During an interview on 2/16/24, at 10:41 a.m., with LVN J, LVN J stated, she started here at the facility a few weeks ago and was not trained on how to use the charting system. During an interview on 2/16/24, at 10:54 a.m., with LVN C, LVN C stated, she has worked here over a few months, and was trained by registry staff for one shift. LVN C stated, the nurse who trained her did not know how to use the charting system either. During a review of the facility's Policy & Procedure (P&P) titled, Staffing, Sufficient and Competent Nursing dated 2022, the P&P indicated, Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. 'Competency' is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 46939 Based on observation, interview and record review the facility failed to post direct care staffing numbers, and nursing staff responsible for direct care to residents for two days (2/14/24-2/15/24) in each three halls of the facility. This failure resulted in residents and visitors not knowing the accurate number of hours of staff working and which staff were scheduled. Findings: During an observation on 2/14/24 at 9 a.m., in Hall BB. No staff schedule or direct patient care hours were seen posted. During an observation on 2/14/24 at 9:15 a.m., in Hall CC . No staff schedule or direct patient care hours were seen posted. During an observation on 2/14/24 at 9:30 a.m., in Hall AA. No staff schedule or direct patient care hours were seen posted. During an observation on 2/15/24 at 9:45 a.m., in Hall BB. No staff schedule or direct patient care hours were seen posted. During an observation on 2/15/24 at 10:01 a.m., in Hall CC. No staff schedule or direct patient care hours were seen posted. During an observation on 2/15/24 at 10:06 a.m., in Hall AA. No staff schedule or direct patient care hours were seen posted. During a concurrent observation and interview on 2/15/24, at 1:31 p.m., with DON A, at nurses station in Hall BB, no staffing schedule, or direct patient care hours were posted. DON A stated, I do not know where the staffing information was, I would have to correct it and have the Director of Staff Development post it in all three hallways, the information is supposed to be posted. During a review of the facility's Policy & Procedure (P&P) titled, Staffing, Sufficient and Competent Nursing, dated 2022, the P&P indicated, Direct care daily staffing number (the number of nursing personnel responsible for providing direct patient care to residents) are posted in the facility to every shift.

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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. 27000 Based on observation, interviews, and record review, the facility failed to provide pharmaceutical services to meet the needs of three out of 24 sampled residents (Residents 56, 76, and 95). Also, the facility failed to ensure morning medication administration was given timely as per facility and procedures for two out of three halls (Hall CC) with the potential to affect 14 residents in this hall; and controlled medications (those with high potential for abuse and addiction) were fully accounted. These happened when: 1. Resident 56's Depakote (medication to treat mood disorder) was not available for administration. This had the potential for untreated medical conditions and withdrawal symptoms; 2. The morning medication administration in Hall CC was given late for two days during the survey. Late medication administration resulted in a medication not given to Resident 56 due to its scheduled time; and may lead to residents' discomfort (such as unnecessary pain) and affecting their health and safety (such as too low/high blood sugar, blood pressure, etc.); 3. There was no documentation of routine medication administration for two days for Resident 56 and 95. This resulted in inaccurate and/or omission errors in medication administration. 4. Controlled medication audit for four out of four residents (Residents 17, 20, 56, and 65) did not reconcile. This had the potential for misuse or diversion of controlled medications; 5. Narcotic Count Sheet Release (a document that is signed by nurses at each shift change to ensure accuracy of controlled substance inventory) logs were incomplete for two out of three inspected medication carts; 6. One of three opened emergency kits (E-kit, a kit/box containing medications and supplies for immediate use during a medical emergency) was not replaced timely to ensure availability of medications for resident use in case of an emergency; and 7. Resident 76's routine Risperdal (an anti-psychotic medication) was not given for four days. This had the potential for untreated behavioral conditions and withdrawal symptoms. Findings: 1. During a medication administration observation with Licensed Vocational Nurse (LVN) C on 2/12/24 at 10:17 a.m., LVN C stated that she does not have the Depakote (divalproex, medication for mood disorder) to give to Resident 56 because it was not available to administer. She stated the nurses were to get them in on Friday, 2/9/24, but it is still not here yet. LVN C reviewed the medication administration record (MAR) dated 2/12/24 and stated that Resident 56 is supposed to get the medication two times a day. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 56's physician's order, dated 12/10/23, indicated for divalproex sodium extended release (ER) 250 mg, give three tablets two times a day (at 8 a.m. and 4 p.m.) for schizoaffective disorder manifested by sudden loud verbal outbursts. During an interview with LVN F on the next day, on 2/13/24 at 9:18 a.m., she looked in the medication cart and stated Resident 56's Depakote was still not in yet. During a concurrent interview and record review with Director of Nursing A (DON A) on 2/13/24 at 4:30 p.m., she stated the nursing staff called the pharmacy today and it will arrive later this afternoon. She reviewed Resident 56's 2/2024 Medication Administration Record (MAR) and acknowledged Resident 56 missed three Depakote doses since Monday morning (2/12/24). During this review, the MAR also reflected there was no Depakote administration during the 8 a.m. medication pass on 2/10 and 2/11/24. The DON stated, I was not here so I don't know what happened. A review of the facility's policy and procedures (P&P) titled Pharmacy Services Overview, dated 4/2019, The facility shall accurately and safely provide or obtain pharmaceutical services, including the provision of routine and emergency medications . Pharmaceutical services consists of . Residents have sufficient supply of their prescribed medications and receive medications (routine, emergency or as needed) in a timely manner. 2. During a concurrent interview and observation on 2/12/24 at 10:08 a.m., LVN C stated she was assigned resident care for part of Hall BB and Hall CC this morning. She stated she will not give Resident 56 her levothyroxine (a thyroid medication) because the medication is supposed to be given before breakfast and Resident 56 already ate breakfast. On 2/12/24 at 10:26 a.m., at Resident 56's bedside, LVN C administered 11 medications to Resident 56 which did not include the levothyroxine. During an interview with Resident 56 on 2/12/24 at 10:46 a.m., she stated she had been waiting for the nurse to give her the Norco (a potent narcotic for pain) as she had a 10 out of 10 pain (worst pain). During another interview with Resident 56 on 2/12/24 at 3:57 p.m., she stated, due to recent staff changes, the morning nurses are usually late and sometimes they do not come until 1 p.m. to administer morning medications. A review of Resident 56's Minimum Data Set (MDS, a resident assessment and screening tool), dated 12/15/23, indicated she had a BIMS score of 15 (Brief Interview for Mental Status, a test given by medical professionals that helps determine a patient's cognitive understanding, scored from 1 to 15), which indicated she was cognitively intact. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 56's medication orders and 2/2024 MAR indicated her levothyroxine was scheduled daily at 6:30 a.m. Her other routine medications included: furosemide (for high blood pressure) twice daily at 8 a.m. and 4 p.m.; Miralax (for bowel movement) twice daily at 8 a.m. and 4 p.m.; divalproex (Depakote) twice daily at 8 a.m. and 4 p.m.; gabapentin (for nerve pain) 3 times daily at 8 a.m., 12 p.m., and 4 p.m.; multi-vitamins daily at 8 a.m., senna (a laxative) daily at 8 a.m., hydroxyzine (for anxiety) twice daily at 8 a.m. and 8 p.m.; lidocaine patch (for back pain) daily at 8 a.m.; Spiriva (for breathing problems) daily at 8 a.m.; QVAR inhaler (for breathing problems) twice daily at 8 a.m. and 4 p.m.; Refresh eye drops (for dry eyes) three times daily at 8 a.m., 12 p.m., and 4 p.m.; and fluticasone nasal spray (for allergies) daily at 8 a.m. On 2/13/24 at 9:19 a.m., in Hall CC, Resident 100 was observed telling LVN F that roommate (Resident 95) has been crying out for pain medication and needs her antibiotic. LVN F stated she will get to her roommate as soon as she can. During an interview with LVN F on 2/13/24 10:10 a.m., she stated the assigned nurse will come over to Hall CC as soon as she is done administering medications in Hall BB. She stated that sometimes the nurses are tied up with residents in Hall BB and would not be able to come to this hall on time. LVN F stated, although she was not assigned, she will help right now as it was already late for the morning medication pass. On 2/13/24 at 10:48 a.m., LVN F and LVN J were observed passing medications in Hall CC. They stated they just started the medication administration in this hall. Resident 100 was observed asking for her roommate's medications again. During an interview with Resident 100, on 2/13/24 at 10:57 a.m., she stated her roommate (Resident 95) gets a pain pill around 9 a.m. and 4 p.m. but has been getting them late during the morning medication pass. She said she understands there has been been a lot of staff changes but the nurses have been late giving medications to her roommate. A review of Resident 95's medication orders included: metformin twice daily 8 a.m. and 4 p.m.; biofreeze gel (topical pain) twice daily at 8 a.m. and 4 p.m.; quetiapine (an antipsychotic) twice daily at 8 a.m. and 4 p.m.; Ativan (for anxiety) 3 times daily at 8 a.m., 12 p.m., and 4 p.m.; gabapentin 3 times daily at 8 a.m., 12 p.m., and 4 p.m.; divalproex three times daily at 8 a.m., 2 p.m., and 8 p.m.; glipizide daily at 8 a.m.; colchicine (for gout) daily at 8 a.m.; amlodipine daily at 8 a.m.; and losartan daily at 8 a.m. During a follow-up interview on 2/13/24 at 12:32 p.m., LVN F stated she finished giving the morning medications to the residents in Hall CC at around 11:30 a.m. She confirmed the morning medications were scheduled at 8 a.m. On 2/13/24, a review of the facility's census indicated Hall CC had 14 residents. During an interview with DON A on 2/13/24 at 4:49 p.m., she stated medications are supposed to be given within 1 hour of scheduled time. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's P&P Administering Medications revised 4/2019, indicated: Medications are administered in accordance with prescriber orders, including any required time frame and Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). 3a. A review of Resident 56's February 2024 MAR indicated the nursing staff left blank (indicating no administration) for 8 AM medication administration on 2/10 and 2/11/24 for the following medications: furosemide, Miralax, divalproex (Depakote), QVAR, Refresh eye drops, hydroxyzine, fluticasone nasal spray, lidocaine patch, multi-vitamins, senna, and Spiriva. 3b. A review of Resident 95's February 2024 MAR indicated the nursing staff left blank for 8 AM medication administration for the following medications on 2/10 and 2/11/24: biofreeze, quetiapine, Ativan, gabapentin, divalproex sodium, glipizide and amlodipine. A review of Resident 95's Minimum Data Set (MDS, a resident assessment and screening tool), dated 11/20/23, indicated she had a BIMS score of 99, which means the resident was unable to complete the assessment. Resident 95 was not interviewable. During a concurrent interview and record review with DON A on 2/15/24 at 10:28 a.m., the DON reviewed and confirmed the missing documentation of routine medication administration at 8 AM on 2/10 and 2/11/24 for both Residents 56 and 95. She stated, I don't know what happened as she tried to call the nurse who was scheduled to work on both days but they did not call her back. A review of the facility's P&P Administering Medications, revised 4/2019, indicated: As required or indicated for a medication, the individual administering the medication records in the resident's medical record . the date and time the medication was administered . and . the signature and title of the person administering the drug. 49613 4a. During an interview with DON B on 2/15/24 at 11:54 a.m., DON B stated that when a resident requests a controlled medication, the nurse removes the medication, signs it out of the count sheet (an inventory sheet that keeps record of the usage of controlled medications), administers the medication to the resident, and documents the administration on the resident's Medication Administration Record (MAR). A review of Resident 17's clinical record indicated the following physician's order: Norco 5 (hydrocodone 5 mg with acetaminophen 325 mg, a potent controlled medication for pain), give one tablet by mouth every 4 hours as needed for moderate/severe pain, dated 11/2/23. During a concurrent interview and record review with DON B on 2/15/24 at 12:47 p.m., a review of Resident 17's count sheets for Norco 5 and the 2/2024 MAR, indicated the nursing staff signed out one tablet on the following dates and times but did not document the administration on the MAR: - 2/4/24 at 1 a.m. - 2/6/24 at 6 a.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 2/7/24 at 4:30 a.m. - 2/7/24 at 3:02 p.m. - 2/8/24 at 2:48 p.m. - 2/8/24 at 8 p.m. - 2/9/24 at 4 a.m. During this interview and record review, DON B confirmed the finding and acknowledged that 7 tablets of Norco 5 for Resident 17 were not accounted for. 4b. A review of Resident 20's clinical record indicated the following physician's order: tramadol (a potent controlled medication for pain) 50 mg, give one tablet by mouth every 6 hours as needed for moderate to severe pain, dated 2/3/24. During a concurrent interview and record review with DON B on 2/15/24 at 12:47 p.m., a review of Resident 20's count sheets for Tramadol 50 mg and the 2/2024 MAR, indicated the nursing staff signed out one tablet on the following dates and times but did not document the administration on the MAR: - 2/5/24 at 12:30 p.m. - 2/9/24 at 9 p.m. During this interview and record review, DON B confirmed the finding and acknowledged that 2 tablets of Tramadol for Resident 20 were not accounted for. 4c. A review of Resident 56's clinical record indicated the following physician's order: Norco 10 (hydrocodone 10 mg with acetaminophen 325 mg, a potent controlled medication for pain), give one tablet by mouth every 4 hours as needed for moderate to severe pain, dated 12/10/23. During a concurrent interview and record review with DON B on 2/15/24 at 12:47 p.m., a review of Resident 17's count sheets for Norco 10 and the 2/2024 MAR, indicated the nursing staff signed out one tablet on the following dates and times but did not document the administration on the MAR: - 2/10/24 at 3 p.m. - 2/10/24 at 7:30 p.m. - 2/12/24 at 6 a.m. During this interview and record review, DON B confirmed the finding and acknowledged that 3 tablets of Norco 10 for Resident 56 were not accounted for. 4d. A review of Resident 65's clinical record indicated the following physician's order: tramadol 50 mg, give one tablet by mouth every 12 hours as needed for moderate pain level 4-7, dated 12/7/22. (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 concurrent interview and record review with DON B on 2/15/24 at 12:47 p.m., a review of Resident 65's count sheets for tramadol and the 12/2023, 1/2024, and 2/2024 MARs, indicated the nursing staff signed out one tablet on the following dates and times but did not document the administration on the MAR: - 12/29/23 at 4:30 p.m. - 12/30/23 at 4 p.m. - 12/31/23 at 4:30 a.m. - 12/31/23 at 5 p.m. - 1/5/24 at 9:15 a.m. - 1/10/24 at 7 p.m. - 2/8/24 at 2 p.m. - 2/12/24 at 9 a.m. During this interview and record review, DON B confirmed the finding and acknowledged that 8 tablets of tramadol for Resident 65 were not accounted for. A review of the facility's P&P titled Administering Medications, revised 4/2019, indicated: The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication . A review of the facility's P&P titled Controlled Substances, revised 11/2022, indicated: The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage; b. Medication administration records. 5. During an inspection of Medication Cart 2 in Hall AA on 2/12/24 at 12:43 p.m., the Narcotic Count Sheet Release (a document that is signed by nurses at each shift change to ensure accuracy of controlled substance inventory) was reviewed for 2/2024. Documentation was incomplete for 8 of 12 dates on the log. Licensed Vocational Nurse (LVN) E verified that the documentation was incomplete. During an inspection of Medication Cart 1 in Hall CC on 2/13/24 at 9:26 a.m., the Narcotic Release log was reviewed for 2/2024. Documentation was incomplete for 9 of 12 dates on the log. Licensed Vocational Nurse (LVN) F verified that the documentation was incomplete. During an interview with Director of Nursing (DON) A on 2/13/24 at 5:04 p.m., DON A stated that the Narcotic Release logs are supposed to be signed at each shift. DON A acknowledged the finding. A review of the facility's policies and procedures (P&P) Controlled Substances, revised 11/2022, indicated: Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count and The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. During an inspection of the Medication Cart 2 in Hall AA on 2/12/24 at 12:43 p.m. in the presence of Licensed Vocational Nurse (LVN) E. , the E-Kit containing controlled medications was observed to be sealed with yellow plastic tags, indicating it had previously been opened. The E-Kit container had a yellow carbon copy of a slip indicating that one tablet of Norco 5 (hydrocodone 5 mg with acetaminophen 325 mg, a potent controlled medication for pain) was used on the following dates and times: 1/13/24 at 4:44 p.m., 1/13/24 at 10:45 p.m., and 1/31/24 at 11:30 p.m. LVN E acknowledged it was first opened on 1/13/24, a month ago. During an interview with Director of Nursing (DON) A on 2/13/24 at 5:01 p.m., DON A stated that E-Kits should have been replaced within 72 hours of opening. DON A acknowledged the e-kit should have been replaced already. A review of the facility's policies and procedures (P&P) Pharmacy Services Overview revised 4/2019, indicated: The facility shall contract with a licensed consultant pharmacist to help it obtain and maintain timely and appropriate pharmacy services that support residents' needs, are consistent with current standards of practice, and meet state and federal requirements. The State law Title 22 CCR S 72377 indicated: The emergency drug supply shall be stored in a portable container . The director of nursing service or charge nurse shall notify the pharmacist when drugs have been used from the emergency kit or when the seal has been broken. Drugs used from the kit shall be replaced within 72 hours and the supply resealed by the pharmacist. 44583 7. Review of Resident 76's face sheet (summary page of a patient's important information), indicated Resident 76 was admitted to the facility with diagnoses including bipolar disorder (mental disorder characterized by periods of elevated mood and depression, often with poor decision-making), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and unspecified psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality). Review of Resident 76's minimum data set (MDS, an assessment tool) quarterly assessment, dated 1/16/2024, indicated Resident 76 was cognitively intact. Review of Resident 76's Physician Orders for the month of February 2024, date ordered 1/5/2023, indicated, RISPERIDONE (Generic name for Risperdal) 3 MG (milligrams, unit of measurement) ODT (orally disintegrating or orally dispersible tablet, dosage forms that dissolve rapidly on contact with saliva) - Give 1 tablet by mouth Q (every) daily/ Bipolar Disorder m/b (manifested by) verbal aggressive behavior towards others. During a concurrent observation and interview with Resident 76 on 2/12/2024 at 10:01 a.m., Resident 76 was seated on her wheelchair. Resident 76 complained she did not get her morning Risperdal for several days already. During a follow up interview with Resident 76 on 2/13/2024 at 8:47 a.m., Resident 76 stated she felt better because she finally got her morning Risperdal. (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 concurrent interview and record review with MDS coordinator (MDSC) on 2/15/2024 at 4:12 p.m., MDSC reviewed Resident 76's February MAR. MDSC confirmed Resident 76 did not received her morning Risperdal on 2/8, 2/9, 2/10 and 2/11/2024. During a concurrent observation and interview with licensed vocational nurse F (LVN F) on 2/16/2024 at 9:59 a.m., LVN F checked Resident 76's stock of Risperdal 3 mg. LVN F confirmed a box of Risperdal 3 mg with 28 tablets was delivered on 2/12/2024. LVN F confirmed there were 23 tablets left in the box. LVN F stated nurses should have order residents medications before they run out of supply.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27000 Based on interviews and record review, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported irregularities during the monthly medication regimen review (MRR), and conducted an interim or immediate MRR (iMRR, an MRR when the medication regimen is thought to contribute to an acute change in condition or adverse effect, or when resident is not expected to stay less than 30 days), for three of 24 sampled residents (Residents 58, 75, and 370) when: 1. The facility did not request for an iMRR by the pharmacist to evaluate whether Resident 58's multiple falls were caused or contributed by medications; 2. The CP failed to make recommendations for Resident 75 who received four medications to control blood sugar (BS) without a hold order when the BS is too low; without hypoglycemia protocol (intervention instructions for when the BS is too low); and without staff monitoring for signs and symptoms of hypo/hyperglycemia (too low/too high blood sugar); 3. The CP failed to make recommendations for Resident 370 who received Lovenox (an anticoagulant to prevent blood clots) and aspirin (an anti-platelet medication; the combined use increases the risk of bleeding) without staff monitoring for signs and symptoms related to anticoagulant use (such as bruising/bleeding); and received two insulin orders without written hypoglycemia protocol and staff monitoring for signs and symptoms of hypo/hyperglycemia. This failure had the potential for medications not being optimized for best possible health outcome, and unnecessary or prolonged use of medications which could lead to medication adverse effects for the residents Findings: 1. A review of Resident 58's medical record indicated she was admitted to the facility with diagnoses including history of strokes, bipolar disorder (condition associated with episodes of mood swings ranging from depressive lows to manic highs), major depressive disorder (MDD, a mood disorder that causes a persistent feeling of sadness and loss of interest), and vascular dementia (brain damage caused by multiple strokes). Further review of her medical record indicated the resident had sustained multiple falls on: 1/19/23, 2/21/23, 8/12/23, and 1/18/24. During an interview with Resident 58 on 2/14/24 at 4:41 p.m., Resident 58 stated she had three falls last year, in 2023. A review of Resident 58's medication orders indicated she had been receiving routine medications that could contribute to falls, including: - Trazodone (an antidepressant), in various doses, for in ability to sleep since 9/18/2020 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Cymbalta (an antidepressant) 30 mg 1 capsule daily for MDD since 9/18/2020 - Zyprexa (an antipsychotic) 5 mg, 1 tablet at bedtime for bipolar disorder since 2/9/22 There was no evidence in Resident 58's medical record indicating an iMRR was conducted after the resident had the falls. During a telephone interview with the CP on 2/15/24 at 12:12 p.m., he stated he would recommend that an iMRR be requested when there are any changes in resident condition that could be related to medication use. When asked if an iMRR was done by a pharmacist related to the resident's falls (on dates above), the CP stated, I don't see any that was done. During a concurrent interview and record review with Director of Nursing B (DON B) on 2/15/24 at 1:10 p.m., she stated an iMRR should be requested when there is a change of condition that could be related to medication use. She stated the facility should have requested for an iMRR for Resident 58 after she has had multiple falls. 2. A review of Resident 75's medical record indicated she was admitted to the facility with diagnoses including type 2 diabetes mellitus (DM, is an impairment in the way the body regulates and uses sugar as a fuel) with hyperglycemia. According to the American Diabetic Association, a normal before-meal BS in individuals with diabetes is 80 - 130 milligrams/deciLiter (unit of measurement) (https://diabetes.org/living-with-diabetes/treatment-care/checking-your-blood-sugar; accessed 2/21/24). A review of Resident 75's physicians orders included the following: a. Novolog (a rapid-acting insulin), inject 3 units subcutaneously (SQ, under the skin) 3 times daily before meals for DM, dated 6/13/23; b. Lantus (a long-acting insulin), inject 10 units SQ daily at bedtime for DM, dated 6/13/23; c. Metformin (anti-diabetic medication used to improve glucose control in people with type 2 DM) 1000 milligrams (mg) twice daily for DM, dated 6/13/23; d. Jardiance (anti-diabetic medication) 10 mg daily for DM, dated 6/13/23 Despite Resident 75 receiving four medications (as above) to control BS, there was no documented evidence in Resident 75's medical record of an order for when to hold the Humalog or calling the doctor; no nursing staff monitoring for signs and symptoms of hypo/hyperglycemia; no prescribed hypoglycemia protocol such as when to administer food or rescue medication when the BS is too low; and no care plan developed for the DM. During a concurrent interview and record review with Director of Nursing B (DON B) on 2/16/24 10:15 a.m., she reviewed Resident 57's medical record and confirmed the above. She stated the CP should have caught it during the month MRR. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview with the CP on 2/16/24 at 11:14 a.m., he stated he did not but should have identified and reported to the facility regarding the lack of hold parameters for the Humalog order, and the lack of monitoring for signs and symptoms related to hypo/hyperglycemia and the hypoglycemia protocol. 3. A review of Resident 370's medical record indicated he was admitted to the facility with diagnoses including type 2 DM and gastritis (when your stomach lining gets red and swollen/inflamed). A review of Resident 370's physician's orders included: a. Lovenox (enoxaparin) 40 mg, inject SQ once daily, dated 1/9/24 b. Aspirin 81 mg, one tablet daily for stroke prevention, dated 1/8/24 c. Admelog (a rapid-acting insulin), administer via sliding scale (a set of instructions for administering insulin dosages based on specific BS readings). If below 70, [follow] Hypoglycemia Protocol. If more than 400, call MD, dated 1/9/24. d. Lantus, inject 25 units SQ daily at bedtime for DM, dated 1/8/24. A review of Resident 370's care plans, dated 1/2024, indicated the resident is at risk for gastrointestinal (GI) distress and GI bleeding due to gastritis and the use of Lovenox. To date, the Prescribing Information for Lovenox indicates to monitor signs and symptoms of bleeding such as bruising that is not normal, nosebleeds, red/black tarry stools, bleeding from the gums, etc. According to [NAME]-Comp, a nationally recognized drug information resource, the combined use Lovenox and aspirin results in a drug-drug interaction (interaction between a drug and another substance that prevents the drug from performing as expected) risk-rating Level D (moderate severity, which means to avoid or consider therapy modification). It indicated, Discontinue antiplatelet agents prior to initiating enoxaparin whenever possible. If concomitant administration is unavoidable, monitor closely for signs and symptoms of bleeding. During a concurrent interview and record review with DON B on 2/16/24 at 10:38 a.m., she confirmed there is no evidence the facility staff monitored for signs and symptoms related to anticoagulation and aspirin use. She also stated there should be an order for monitoring signs/symptoms related to hypo/hyperglycemia; and a written hypoglycemia protocol so the staff knows what to carry out in case the resident is hypoglycemic. During a telephone interview with the CP on 2/16/24 at 11:20 a.m., he confirmed he did not make a recommendation for the nursing staff to monitor signs and symptoms related to hypo/hyperglycemia and for Lovenox and aspirin use. He stated, Yes, I should have made the recommendations for those. A review of the facility's policy and procedure titled MEDICATION REGIMEN REVIEW (MONTHLY REPORT), dated 6/2021, indicated: The consultant pharmacist reviews the medication (MRR) for each resident at least monthly . (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	While MRRs are generally monthly, a more frequent remote iMRR may be deemed necessary if the medication regimen is thought to contribute to an acute change in condition or adverse consequence . The director of nursing or charge nurse notifies the consultant pharmacist of clinical pharmacist . The consultant pharmacist or designee . works with facility personnel and electronic records to gather pertinent information related to the resident's status and/or request for consultation. The findings are phoned, faxed, or e-mailed to the director of nursing or designee and documented . Resident-specific irregularities and/or clinically significant risks resulting from or associated with medications are documented and reported to the Director of Nursing, and/or prescriber as appropriate.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27000 Based on interviews and record review, the facility failed to ensure two of 24 sampled residents (Residents 75 and 370) were free from unnecessary medications when: 1. Resident 75 received two routine insulin (medication to lower blood sugar [BS]) and two other medications to control BS without a hold order when the BS is too low; without hypoglycemia protocol (intervention instructions for when the BS is too low); without staff monitoring for signs and symptoms of hypo/hyperglycemia (too low/too high blood sugar); and without a written care plan for diabetes; and 2. Resident 370 received Lovenox (an anticoagulant to prevent blood clots) and aspirin (an anti-platelet medication; the combined use increases the risk of bleeding) without staff monitoring for signs and symptoms related to anticoagulant use (such as bruising/bleeding); and received two insulin orders without written hypoglycemia protocol and staff monitoring for signs and symptoms of hypo/hyperglycemia. These failures had the potential for side effects of these medications to go undetected or recognized for timely intervention. Findings: 1. A review of Resident 75's medical record indicated she was admitted to the facility with diagnoses including type 2 diabetes mellitus (DM, is an impairment in the way the body regulates and uses sugar as a fuel) with hyperglycemia. According to the American Diabetic Association, a normal before-meal BS in individuals with diabetes is 80 - 130 milligrams/deciLiter (unit of measurement) (https://diabetes.org/living-with-diabetes/treatment-care/checking-your-blood-sugar; accessed 2/21/24). A review of Resident 75's physicians orders included the following: a. Novolog (a rapid-acting insulin), inject 3 units subcutaneously (SQ, under the skin) 3 times daily before meals for DM, dated 6/13/23; b. Lantus (a long-acting insulin), inject 10 units SQ daily at bedtime for DM, dated 6/13/23; c. Metformin (anti-diabetic medication used to improve glucose control in people with type 2 DM) 1,000 milligrams (mg) twice daily for DM, dated 6/13/23; d. Jardiance (anti-diabetic medication) 10 mg daily for DM, dated 6/13/23 (continued on next page)

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	555831	A. Building B. Wing	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Herman Health Care Center	2295 Plummer Avenue San Jose, CA 95125

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Despite Resident 75 receiving four medications (as above) to control BS, there was no documented evidence in Resident 75's medical record of an order for when to hold the Humalog or calling the doctor; no nursing staff monitoring for signs and symptoms of hypo/hyperglycemia; no prescribed hypoglycemia protocol such as when to administer food or rescue medication(s) when the BS is too low; and no care plan developed for the DM. During a concurrent interview and record review with Director of Nursing B (DON B) on 2/16/24 10:15 a.m., she reviewed Resident 57's medical record and confirmed the above. She stated there should be a hold order when the BS is too low, such as when it is below 70 mg/dL. She also confirmed there was no prescribed hypoglycemia protocol with interventions such as to give juice/food or medication such as D50W (dextrose in 50% water) when the BS is too low; and no monitoring of hypo/hyperglycemia symptoms (such as sweating, shakiness, pale looking, headache .etc.). DON B stated those should have been included in Resident 75's orders. 2. A review of Resident 370's medical record indicated he was admitted to the facility with diagnoses including type 2 DM and gastritis (when your stomach lining gets red and swollen/inflamed). A review of Resident 370's physician's orders included: a. Lovenox (enoxaparin) 40 mg, inject SQ once daily, dated 1/9/24 b. Aspirin 81 mg, one tablet daily for stroke prevention, dated 1/8/24 c. Admelog (a rapid-acting insulin), administer via sliding scale (a set of instructions for administering insulin dosages based on specific BS readings). If below 70, [follow] Hypoglycemia Protocol. If more than 400, call MD, dated 1/9/24. d. Lantus, inject 25 units SQ daily at bedtime for DM, dated 1/8/24. A review of Resident 370's care plans, dated 1/2024, indicated the resident is at risk for gastrointestinal (GI) distress and GI bleeding due to gastritis and the use of Lovenox. To date, the Prescribing Information for Lovenox indicates to monitor signs and symptoms of bleeding such as bruising that is not normal, nosebleeds, red/black tarry stools, bleeding from the gums, etc. According to [NAME]-Comp, a nationally recognized drug information resource, the combined use Lovenox and aspirin results in a drug-drug interaction (interaction between a drug and another substance that prevents the drug from performing as expected) risk-rating Level D (moderate severity, which means to avoid or consider therapy modification). It indicated, Discontinue antiplatelet agents prior to initiating enoxaparin whenever possible. If concomitant administration is unavoidable, monitor closely for signs and symptoms of bleeding. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/16/24 at 9:53 a.m., a concurrent interview and record review of Resident 370's medical record was conducted with Registered Nurse L (RN L), a registry nursing staff (licensed or certified staff who receives compensation from a third party agency to work at a nursing care institution). She stated she could not find evidence the nursing staff monitored for signs and symptoms of adverse effects of Lovenox and aspirin. After reviewing the order for Admelog, she stated she did not know how or where to locate the hypoglycemia protocol. During a concurrent interview and record review with DON B on 2/16/24 at 10:38 a.m., she confirmed there should be orders for staff to monitor for signs and symptoms related to anticoagulation and aspirin use. She also stated there should be an order for monitoring signs/symptoms related to hypo/hyperglycemia, and a written hypoglycemia protocol so the staff knows what to carry out in case the resident is hypoglycemic. A review of the facility's Diabetes - Clinical Protocol, revised 11/2020, indicated, The Physician will order desired parameters for monitoring and reporting information related to blood sugar management . The staff will incorporate such parameters into the Medication Administration Record and care plan. The staff will identify and report issues that may affect, or be affected by, a patient's diabetes and and diabetes management such as hypoglycemia. A review of the facility's Anticoagulation - Clinical Protocol, revised 11/2018, indicated the physician and staff [a]ssess for any signs or symptoms related to adverse drug reactions due to the medication alone or in combination with other medications and will monitor for possible complications in individuals who are being anticoagulated .

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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. 49613 Based on observation, interview, and record review, the facility had a medication error rate of 14.29% when five medication errors occurred out of 35 opportunities during the medication administration for one out of five residents (Resident 56). The failures resulted in medications not given according to the physician's orders and had the potential for Resident 56 to not receive the full therapeutic effects of the medications. Findings: 1. During an observation on 2/12/24 at 10:08 a.m., while preparing medications for Resident 56, Licensed Vocational Nurse C (LVN C) stated she needed Refresh Tears eye drops. On 2/12/24 at 10:20 am., LVN D was observed bringing a bottle of Gericare Artificial Tears eye drops for LVN C to give to Resident 56. During a medication pass observation on 2/12/24 at 10:26 a.m., LVN C was observed administering 11 medications to Resident 56. The medications included Gericare Artificial Tears eye drops. A review of Resident 56's physician's order, dated 12/27/23, indicated Refresh Tears 0.5% eye drop, give 1-2 drops in both eyes three times daily for dry eyes (at 8 a.m., 12 p.m., and 4 p.m.). During a concurrent interview and observation on 2/13/24 at 9:18 a.m., LVN F stated that there were no Refresh Tears eye drops in the medication cart for Resident 56, only Artificial Tears eye drops. LVN F acknowledged that Refresh Tears eye drops and Artificial Tears eye drops are not the same. A review of the Drug Label for Refresh Tears dated 6/30/22, retrieved from DailyMed (a website operated by the U.S. National Library of Medicine to publish up-to-date and accurate drug labels to health care providers and the general public, provided and updated daily by the U.S. Food and Drug Administration), indicated that the active ingredient is carboxymethylcellulose sodium 0.5%. A review of the Drug Label for Gericare Artificial Tears dated 10/30/23, retrieved from DailyMed, indicated that the active ingredients are glycerin 0. 2%, hypromellose 0.2%, and polyethylene glycol-400 1%. 2. While preparing medications for Resident 56 on 2/12/24 at 10:17 a.m., LVN C stated that she does not have the Depakote (divalproex, medication for mood disorder) to give to Resident 56 because it was not available to administer. LVN C reviewed the medication administration record (MAR) dated 2/12/24 and stated that Resident 56 is supposed to get the medication two times a day. A review of Resident 56's physician's order, dated 12/10/23, indicated for divalproex sodium extended release (ER) 250 mg, give three tablets two times a day (at 8 a.m. and 4 p.m.) for schizoaffective disorder manifested by sudden loud verbal outbursts. A review of Resident 56's 2/2024 MAR indicated LVN C placed an N (not administered) for the 2/12/24 entry at 8 a.m. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a concurrent interview and observation on 2/12/24 at 10:08 a.m., LVN C stated that she will not give Resident 56 her levothyroxine (thyroid medication) because the medication is supposed to be given before breakfast and Resident 56 already ate breakfast. A review of the physician's order indicated that Resident 56 gets levothyroxine 25 micrograms (mcg, unit of measurement) tablet once daily (at 6:30 a.m.) at least 30 minutes before breakfast. A review of the Prescribing Information (PI, detailed description of a drug's uses, dosage range, side effects, drug-drug interactions, and contraindications that is available to clinicians) for levothyroxine tablets, dated 12/2/23, retrieved from DailyMed indicated, Administer once daily, preferably on an empty stomach, one-half to one hour before breakfast with a full glass of water. 4. During the medication pass observation with LVN C above on 2/12/24 at 10:26 a.m., the 11 medications administered to Resident 56 did not include polyethylene glycol (Miralax, medication for bowel movement) and fluticasone nasal spray (for allergies). A review of Resident 56's physicians orders indicated the following: - Polyethylene glycol 3350 powder, give 17 grams two times a day (at 8 a.m. and 4 p.m.) for bowel management, dated 12/10/23. - Fluticasone 50 micrograms one spray in each nostril once daily (at 8 a.m.) for allergy, dated 12/10/23. During an interview on 2/12/24 at 2:34 p.m., LVN C verified that she did not give the Miralax and fluticasone to Resident 56 in the morning as ordered. During an interview with DON A on 2/13/24 at 4:29 p.m., she stated her expectation is that medications are given within one hour of the ordered time. A review of the facility's P&P Administering Medications revised 4/2019, indicated: Medications are administered in accordance with prescriber orders, including any required time frame and Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49613 Based on observation, interview, and record review, the facility failed to ensure medications were stored and labeled appropriately when: - One of three medication refrigerators was identified unlocked when not in use; and its temperature was not being monitored and maintained twice daily as per professional standards of practice. This failure could lead to loss of medications and loss of drug potency due to unmonitored temperatures; - An opened multi-dose eye drop in the medication cart was not labeled with a resident name. The failure had the potential for the medication being used for the incorrect resident; - A package of expired blood sugar test strips was found in the medication cart. The failure could lead to the product being used past its effective date; - A bottle of Lorazepam (medication to treat anxiety) Intensol solution was found stored at room temperature in the medication cart. The medication was supposed to be stored in the fridge. This failure could lead to loss of drug potency and product stability; - An opened insulin lispro (an injectable pen containing insulin, a hormone that regulates blood sugar) in the medication cart was incorrectly dated with a 54 day expiration date. This failure had the potential for the medication to be administered past the true 28 day expiration date. Findings: 1. During a visit to Medication Room in Hall AA with Licensed Vocational Nurse (LVN) E on [DATE] at 1:14 p. m., a medication refrigerator was identified unlocked. A brief review of the contents inside revealed the refrigerator contained numerous medications including 3 boxes of flu vaccine and 3 syringes of pneumococcal vaccine (vaccine used to help prevent infections caused by certain types of germs or bacteria called pneumococcus). LVN E verified that the medication refrigerator was supposed to be locked. During a concurrent observation, interview, and record review in Medication Room in Hall AA on [DATE] at 1:28 p.m., the medication refrigerator temperature log was reviewed and noted to be incomplete. The refrigerator temperature was only documented once a day from [DATE] to [DATE]. The refrigerator temperature was not documented on [DATE] or [DATE]. LVN E verified the refrigerator temperature log was incomplete and that the staff were checking only one time a day. During an interview with Director of Nursing (DON) A on [DATE] at 5:04 p.m., she acknowledged and stated the medication refrigerator was supposed to be locked when not in use, and that the temperature monitoring and documentation should be two times per day. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Centers for Disease Control and Prevention's Vaccine Storage and Handling Toolkit, updated ,d+[DATE], indicated to check and record the current temperature a minimum of two times per workday (at the start and end of the workday) for vaccine storage units. A review of the facility's policies and procedures (P&P) titled Storage of Medications revised ,d+[DATE] indicated Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use. 2. During an inspection of Medication Cart 2 in Hall AA on [DATE] at 12:39 p.m. with LVN E, the following were identified and confirmed with LVN E: a. An opened package of Artificial Tears eye drop with no resident name was identified. LVN E stated that the eye drops were supposed to be labeled with the resident name. b. An expired package of blood sugar test strips was observed. LVN E verified that the test strips expired on [DATE]. c. A bottle of Lorazepam Intensol was observed stored at room temperature. LVN E acknowledged that the medication was supposed to be stored in the refrigerator. d. An opened Admelog SoloStar (insulin lispro) injection pen was observed with incorrect date labeling. The insulin pen was labeled open on [DATE], discard on [DATE] (54 day expiration). LVN E stated that the discard date for opened insulin pens is 28 days. LVN E acknowledged that the discard date was labeled incorrectly. A review of the Prescribing Information (PI, detailed description of a drug's uses, dosage range, side effects, drug-drug interactions, and contraindications that is available to clinicians) for Lorazepam Intensol, dated [DATE], indicated: Store at cold temperature. Refrigerate at 2 C [degrees Celsius] to 8 C. A review of the PI for Admelog SoloStar, dated [DATE], indicated In-use (opened) ADMELOG vials and ADMELOG SoloStar pens must be used within 28 days or be discarded, even if they still contain ADMELOG. During an interview with DON A on [DATE] at 5:00 p.m., she acknowledged and stated eye drops are for individual residents and need to be labeled with the resident's name. A review of the facility's P&P titled Storage of Medications revised ,d+[DATE] indicated Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed and Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the dispensing pharmacy or destroyed. A review of the facility's P&P titled Labeling of Medication Containers revised ,d+[DATE] indicated Labels for individual resident medications include all necessary information, such as . the resident's name . and expiration date when applicable.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46553 Based on observation, interview, and record review, the facility failed to ensure food was stored, prepared, and served in accordance with professional standards for food safety when: 1. The kitchen refrigerator door has ice buildup in the rubber gasket (a flexible elastic strip attached to the outer edge of a refrigerator); 2. Three pieces of colored chopping board are stained and two cloudy and one cracked blender container in the kitchen sink; and 3 The snacks /nourishment in the unit refrigerator were outdated. These failures had the potential to cause food contamination and spread food-borne illness to residents who received their food from the kitchen. Findings: 1.During an initial kitchen concurrent observation and interview on 2/12/24 at 11:06 a.m., with the Dietary Staff V (DS V) inside the kitchen's one of the refrigerators. There were some ice buildups and leak at the surrounding refrigerator door rubber gasket . DS V confirmed the observation above. DS V stated the refrigerator should not have ice buildup. DS V further stated the refrigerator was cleaned every day and manage by the Maintenance Director (MD). During a concurrent observation and interview on 2/12/24 at 11:15 a.m., with the MD verified the above observation of the refrigerator door rubber gasket has leak and with ice buildup. MD further stated the refrigerator door rubber gasket should not have ice buildup and he stated it was recently fixed more than a week. MD stated requested the service vendor a new rubber gasket. During an interview on 2/14/24 at 8:18 a.m., with Dietary Manager (DM), stated the kitchen refrigerator should not have ice buildup. During a follow up interview on 2/16/24 at 9:29 a.m., with MD, stated he don't have the copy of the receipt of maintenance refrigerator. He stated he called the vendor yesterday to fixed it, but not answering. He would follow up again. The 2022 Food Code Section 4-501.11 indicates that proper maintenance of equipment to manufacturer specifications that helps ensure that it will continue to operate as designated refrigeration units in disrepair may no longer be capable of proper cooling or holding time/temperature control for safety foods at safe temperature. During review of facility's policy and procedure (P&P), titled, Refrigerators and Freezer, revised 2022, indicated, Refrigerator and or/freezer are maintained in good working condition. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2a. During an initial kitchen observation and interview on 2/12/24 at 10:54 a.m., with DM there were three colored chopping boards beside the microwave with cuts and stained. DM confirmed the observation and stated those chopping board should have been tossed and not be used. 2b. During a concurrent observation and interview on 2/13 /24 at 8:18 a.m., with the DM in the kitchen, two blender container was cloudy, and one blender container is cracked inside. DM verified the blender container was cloudy and cracked inside. The 2022 FDA Food Code, Section 4-602.11, indicates that utensils should be clean to sight and touch. During review of facility's policy and procedure (P&P), titled, Sanitation , dated 2023, indicated, All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas . 3. During a concurrent observation interview on 2/14/24 at 10:28 a.m., with Certified Nurse Assistant Q (CNA Q) and CNA X in Hall BB's resident unit refrigerator there were several foam food container with yogurts and ten sandwiches dated 2/13/24, four sandwich dated 2/11/24, and three sandwich dated 2/10/24 beyond use date. CNA Q verified above observation and stated the sandwich should have been tossed. During a concurrent observation and interview on 2/14/24 at 10:38 a.m., with Licensed Vocational Nurse D (LVN D), verified the yogurt and sandwich date are 2/13/24. LVN D stated those yogurt and sandwiches should not been given to the resident. During an interview on 2/14/24 at 3:39 p.m., with LVN F, stated food coming from the kitchen facilities and with beyond the use by date and should have been discarded. During a concurrent follow up observation and interview on 2/15/24 at 10:03 a.m., with Registered Nurse (RN) W at Hall BB in the resident unit refrigerator, there were two apple sauce in foam food container dated 2/11/24. She verified above observation and stated it should be tossed and not be used. During an interview on 2/15/24 at 3:21 p.m., with master's in science Register Dietician Nutritionist (MSRDN), food inside the unit refrigerator should be check and tossed beyond use date. During review of facility's policy and procedure (P&P), titled, Food receiving and Storage , revised 07/2014, indicated, Food items and snacks kept on the nursing unit must be maintained as indicated below: b. All food belonging to resident must be labeled with the resident's name, the item and the USE BY date .

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 46553 Based on observation, interview, and document review, the facility failed to ensure garbage was properly contained when one of the receptacles lid was not tight-fitting and cannot close. This failure had the potential to attract insects, rodents, and other pests to the facility. Findings: During a concurrent observation and interview on 2/14/24 at 8:35 a.m., accompanied by the maintenance director (MD), there were two dumpsters in the facility's designated waste area, one of the receptacles was for cardboard and one receptacle for garbage. The receptacle lids for the garbage were defective and cannot close. MD confirmed the above observation on defective receptacle lid. The MD stated the receptacle lids were supposed to be closed and acknowledged the defective receptacles lid could attract pests. The United States Food and Drug Administration's 2022 Food Code indicated, Refuse, recyclables, and returnable shall be stored in receptacles or waste handling units so that they are inaccessible to insects and rodents. The Food Code further indicated, Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. During a review of the facility's policy and procedure (P&P) titles , Food-Related Garbage and Refuse Disposal, revised 10/2017, the P&P indicated, All garbage and refuse containers are provided with tight fitting lids or cover and must be kept covered when stored or not in continuous use ; further policy Garbage and refuse containing food wastes will be stored in a manner that is inaccessible to pest; and Outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter.

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. 44583 Based on interview, and record review, the facility failed to update and/or revised their policy and procedure in compliance with Federal regulations and with accepted professional standards and principles when the facility did not revise the facility's bed safety policy and procedure upon completion of the facility's recertification survey's plan of correction (POC). This failure had the potential to compromise resident's health and safety. Findings: Review of the facility's policy and procedure titled, Bed Safety, indicated the revision date was December 2007. During an interview with director of nursing (DON) on 4/12/2024 at 10:59 a.m., DON stated the policy and procedure should have been updated when the POC was completed. DON further stated, based on my practice, we should have reviewed the policy and procedure quarterly since the regulations changed. During an interview with administrator (ADM) on 4/12/2024 at 1:25 p.m., ADM stated facility's policy and procedure should have been reviewed annually or if something needed to be changed. ADM confirmed the policy and procedure titled, Bed Safety, was reviewed but not updated. ADM stated, it should have been revised.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 46553 Based on observation, interview and record review, the facility failed to maintain an infection prevention and control program to prevent the spread of infections when: 1. A dietary staff (DS) failed to perform hand hygiene between tasks that required hand washing; 2. Licensed vocational nurse E (LVN E) did not clean Resident 61's nasal cannula (NC - a device that consists of plastic tube that fits behind the ears, and a set of two prongs that are placed in the nostrils for oxygen administration) before placing it back on Resident 61's nostrils; 3. A nursing staff failed to employ proper infection control procedures during the medication administration for Residents 12 and 33. These failures had the potential for residents to be at increased risk of healthcare-associated infections. Findings: 1. During a concurrent kitchen observation and interview on 2/12/24 at 10:57 a.m., with DS R, during observation DS R was standing in front of the stove wearing a pair of gloves when he picked up his name plate on the floor and put back on his shirt. Further observation DS R keep on touching his hair and bare skin (not covered by clothing) with his gloves. Another DS S translated for DS R, stated about the glove's incident. DS R verified he was wearing gloves and picked up the name plate in the floor. DS R stated gloves should be changed every time touching dirty things. During an interview on 2/12/24 at 11: 06 a.m., with Dietary Manager (DM), stated gloves should be change for every task and wash their hand. The 2022 Food Code Section 2-301.14 (I), title, When to Wash indicates that after engaging in other activities that contaminates the hands. During review of facility's policy and procedure (P&P), titled Gloves Use Policy, dated 2023, indicated When gloves need to be changed: 2. Before beginning a different task; and 7. After touching bare skin or hair. 44583 2. During an observation on 2/12/2024 at 9:36 a.m., Resident 61 was lying in bed, with oxygen concentrator at bedside and the NC was on the floor. During a concurrent observation and interview with LVN E on 2/12/2024 at 10:19 a.m., in Resident 61's room, LVN E placed the NC back to Resident 61's nostrils and turned on the oxygen at 3 liters per minute (LPM). LVN E confirmed she did not clean the NC prior to application back to Resident 61's nostrils. LVN E stated she should have cleaned or changed the NC to prevent Resident 61 from having respiratory infection. (continued on next page)

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	555831	A. Building B. Wing	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Herman Health Care Center	2295 Plummer Avenue San Jose, CA 95125

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Centers for Disease Control and Prevention's (CDC) recommendations and reports titled, Guidelines for Preventing Health-Care-Associated Pneumonia, 2003, dated March 26, 2004, indicated, 1. General measures: a. Thoroughly clean all equipment and devices to be sterilized or disinfected .c. Preferably use sterile water for rinsing reusable semicritical respiratory equipment and devices when rinsing is needed after they have been chemically disinfected. If this is not feasible, rinse the device with filtered water or tap water, and then rinse with isopropyl alcohol and dry with forced air . 49613 3. During a medication pass observation on 2/12/24 at 9:24 a.m., LVN E was observed preparing and administering four medications to Resident 12, including a fluoxetine (for depression) capsule. LVN E used bare hands to open up the capsule to prepare the medication for the resident. During a medication pass observation on 2/12/24 at 9:41 a.m., LVN E was observed preparing seven medications for Resident 33. The medications included Artificial Tears eye drops (for dry eyes) and half-tablet of vitamin D (a supplement) 2,000 international units. LVN E was observed using the pill cutter to cut the vitamin D tablet but she did not clean or sanitize the pill cutter before returning it to the medication cart. On 2/13/24 at 9:45 a.m., a Resident 33's bedside, LVN E touched the bed remote control with bare hands to raise the head of the bed and then administered the eye drops for Resident 33 without performing hand hygiene and putting on gloves between these tasks. During an interview with LVN E on 2/12/24 at 9:50 a.m., LVN E stated she was supposed to wear gloves when administering eye drops. LVN E also stated that she was supposed to wear gloves when opening up the medication capsule. LVN E also acknowledged that she did not wipe the pill cutter after use and was supposed to sanitize it with an alcohol pad after use to prevent cross-contamination of medications. During an interview with DON A on 2/13/24 at 4:59 p.m., DON A stated that wearing gloves when opening up a medication capsule and when administering eye drops is standard nursing practice. A review of the facility's policies and proceduresAdministering Medications, revised 4/2019, indicated: Staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44733 Based on interview and record review, the facility failed to offer, administer, and track Influenza vaccine (known as flu shot, immunization against infection by influenza viruses), pneumococcal vaccine (PV, immunization against bacterial that causes pneumonia, one type of lung infection), and COVID-19 vaccine (immunization against COVID-19 [Coronavirus, a severe respiratory illness caused by a virus and spread from person to person]) for three of 24 sampled residents (Residents 12, 52, and 370). This failure had the potential to cause the health complications for the residents. Findings: 1. A review of Resident 12's clinical record indicated that Resident 12 was admitted on [DATE]. A review of Resident 12's informed consent for the influenza vaccine dated 9/22/2022 indicated that the responsible party (RP, the person who is accountable for making decisions on behalf of the resident) consented for the influenza vaccine to be given. A review of the immunization list provided by the facility, indicated there was no evidenced documentation indicating Resident 12 received the influenza vaccine in 2022. During an interview and record review on 2/16/2024 at 9:55 a.m. with the Director of Staff Development Consultant (DSDC), he stated he could not locate any documentation indicating the influenza vaccine was given in 2022 for Resident 12. The DSDC acknowledged the influenza vaccine should have been given to the resident, and the facility should have the documentation. The DSDC also stated he could not locate any documentation regarding the pneumococcal vaccine for Resident 12. The DSDC acknowledged that the facility should have tracked the pneumococcal record for Resident 12. 2. A review of Resident 52's clinical record indicated that Resident 52 was admitted on [DATE]. During an interview and record review on 2/16/2024 at 10 a.m. with the DSDC, he stated he could not locate any documentation regarding the influenza vaccine, pneumococcal vaccine, or COVID-19 vaccine for Resident 52. The DSDC acknowledged that the facility should have tracked the immunization record for Resident 52. During an interview and record review on 2/29/2024 at 11:08 a.m. with the Minimum Data Set Coordinator (MDSC), he acknowledged the facility should track the resident immunization record and offer any eligible vaccine, and document. The MDSC confirmed Resident 52's MDS section O 0250 influenza vaccine was marked No and the reason not received was marked Offered and declined, and 0300 pneumococcal vaccine was marked No and the reason not received was marked Offered and declined. The MDSC stated there was no evidenced documentation indicating the vaccines were offered to Resident 52 but declined. 3. A review of Resident 370's clinical record indicated that Resident 370 was admitted on [DATE]. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 2/16/2024 at 9:50 a.m. with the DSDC, he stated he could not locate any documentation regarding the influenza vaccine, pneumococcal vaccine, and COVID-19 vaccine for Resident 370 when the surveyor requested the documentation on 2/15/2024. The DSDC acknowledged that the facility should have tracked the immunization record for Resident 370. The DSDC further stated that the facility found out that Resident 370 was eligible for the influenza vaccine and the pneumococcal vaccine and would follow up. During an interview and record review on 2/29/2024 at 11:08 a.m. with the Minimum Data Set Coordinator (MDSC), he confirmed Resident 370's MDS section O 0250 influenza vaccine was marked No and reason not received was marked None of above, and 0300 pneumococcal vaccine was marked No and reason not received was marked Offered and declined. The MDSC stated there was no evidenced documentation indicating the pneumococcal vaccine was offered to Resident 370 but declined. The MDSC also stated there was no documentation regarding why the influenza vaccine was not administered to Resident 370. During a review of the facility's policy and procedure (P&P) titled Vaccination of Residents, revised 10/2019, the P&P indicated, All residents will be offered vaccines that aid in preventing infectious disease unless the vaccine is medically contraindicated or the resident has already been vaccinated. All new residents shall be assessed for current vaccination status upon admission. If vaccines are refused, the refusal shall be documented in the resident's medical record.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on observation, interview, and record review, the following multi-resident rooms provided less than 80 square feet per resident: Findings: [NAME] Hall Rooms: Room Total Sq. Ft. Sq. Ft/Bed No. of Beds 8 289 72 4 9 298 74 4 10 288 72 4 11 298 74 4 17 297 74 4 19 298 74 4 22 299 74 4 [NAME] Hall Rooms: Room Total Sq. Ft. Sq. Ft/Bed No. of Beds 29 297 74 4 31 300 75 4 33 301 75 4 34 299 74 4 36 300 75 4 38 299 74 4 40 302 75 4 (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	None of the rooms were observed to inhibit the staff from providing care or the residents from receiving adequate care. The staff and the residents moved freely in the rooms. The residents and the staff stated the square footage of the rooms was not a concern. Continuance of the room waiver is recommended.