STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555927	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pih Health Good Samaritan Hospital D/P Snf	1225 Wilshire Blvd Los Angeles, CA 90017

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 43851 Based on interview and record review, the facility failed to ensure residents' Minimum Data Set assessments (MDS, a federally mandated resident assessment tool) were transmitted timely to the Center for Medicare Services (CMS) system for two of 10 sampled residents (Resident 3 and Resident 4). This deficient practice had the potential to result in delayed services for Resident 3 and Resident 4. Findings: A review of Resident 3's Facesheet Report indicated the facility admitted the resident on 3/27/2024 with a diagnoses including right femur fracture (broken thighbone) and was discharged from the facility on 4/10/2024. A review of Resident 3's MDS dated [DATE], indicated the resident was cognitively intact (has the ability to think, remember, express thoughts and make decisions). The MDS indicated Resident 3 was independent with eating and required set up or clean up assistance with oral hygiene. The MDS indicated Resident 3 required supervision or touching assistance for upper body dressing and personal hygiene. The MDS indicated Resident 3 required substantial / maximal assistance for toileting hygiene, lower body dressing, and putting on/taking off footwear. A review of Resident 4's Facesheet Report indicated the facility admitted the resident on 3/23/2024 with diagnoses including cellulitis (a deep infection of the skin caused by bacteria) and sepsis (a life-threatening emergency that happens when your body's response to an infection damages vital organs and can lead to death). The Facesheet Report further indicated Resident 4 was discharged from the facility on 4/24/2024. A review of Resident 4's MDS dated [DATE], indicated the resident was cognitively intact, was independent with eating, and required supervision or touching assistance for oral and personal hygiene. The MDS indicated Resident 4 required partial / moderate assistance for upper body dressing and was dependent on help for toileting hygiene. During a concurrent interview and record review on 10/2/2024 at 2:19 PM, the facility's Transmission File Listing Report was reviewed with the MDS Coordinator (MDS 1). MDS 1 stated Resident 3's admission MDS assessment was completed on 4/8/2024 and transmitted to CMS on 4/29/2024. MDS 1 stated Resident 3's discharge assessment was completed on 4/10/2024 and transmitted to CMS on 4/29/2024. MDS 1 stated Resident 4's Entry assessment was completed on 3/25/2024 and transmitted on 4/12/2024. (continued on next page)

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

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MDS 1 stated Resident 4's Admission MDS assessment was completed on 4/4/2024 and transmitted on 5/9/2024. MDS 1 stated the facility had 14 days from the completion date to transmit the assessments to CMS. MDS 1 stated Resident 3's admission MDS assessment and discharge MDS assessments were transmitted to CMS late. MDS 1 stated Resident 3's admission MDS assessment should have been transmitted on 4/22/2024 and the discharge MDS assessment should have been transmitted on 4/24/2024. MDS 1 stated Resident 4's entry and admission MDS assessments were both transmitted late. MDS 1 stated Resident 4's entry MDS assessment should have been transmitted on 4/8/2024 and the admission MDS assessment should have been transmitted on 4/18/2024. MDS 1 further stated transmitting the assessments late indicated CMS would not get the resident information timely, which could potentially lead to a delay in care. During an interview on 10/4/2024 at 12:24 PM, the Director of the Transitional Care Unit (DTCU) stated the MDS assessments should be submitted timely to CMS within 14 days of completion. The DTCU stated they were aware the MDS assessments were not completed timely because MDS 1 remained in training at the time. The DTCU stated the assessments for Residents 3 and 4 were not transmitted timely. A review of the facility's policy and procedure titled, Resident Assessment Instrument (RAI) Process - E. 69010.10, dated 10/13/2022, indicated the MDS must be completed timely and accurately with appropriate signature from the interdisciplinary team. The RAI assessments consist of two types: Omnibus Budget Reconciliation Act (OBRA) assessments are federally mandated and must be completed timely and accurately on all residents regardless of payor source by the assigned due date: a. Admission: (required by 14th calendar day of resident's admission) (admitted +13 calendar dates). Discharge: discharge date + 14 calendar days, Submission: 1. The MDS Coordinator was responsible for the submission of all assessments with corresponding PDPM codes to the Center for Medicare and Medicaid Services (CMS) via QIES Assessment Submission and Processing (ASAP) system. QIES will send a validation for all submitted assessments and appropriate PDPM codes.

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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. 44309 Based on interview and record review, the facility failed to ensure comprehensive, resident -centered care plans were developed for four of ten sampled residents (Residents 111, 115, 163 and 166). For Resident 111 the facility failed to develop a care plan to address the resident's non-compliance to take medications. -For Resident 115 the facility failed to develop a care plan with person centered interventions for psychotropic medication (medications that affect brain activities associated with mental processes and behavior) use. -For Resident 163 the facility failed to develop a care plan including measurable goals and interventions to monitor oxygen use. -For Resident 166 the facility failed to develop a care plan including measurable goals and interventions for the resident's multiple wounds. These deficient practices had the potential for the residents to receive inadequate care and services. Findings: a. A review of Resident 111's Facesheet Report, indicated the facility admitted the resident on 9/25/2024 with a diagnoses including right foot gangrene (a serious condition that occurs when tissue in the body dies due to a lack of blood supply usually caused by a bacterial infection). A review of the Physician's Orders dated 9/25/2024, indicated Resident 111 was to receive the following: -Septra DS (a medication used to treat infections caused by bacteria) 1 tablet by mouth two times daily with meals for skin and soft tissue infection. -Famotidine (Pepcid, a medication used to treat conditions caused by too much stomach acid, such as heartburn, stomach ulcers, and reflux disease) 20 milligrams (mg) by mouth daily for gastroesophageal reflux disease (GERD, a condition that occurs when stomach contents leak back into the esophagus, causing irritation and heart burn). -Aspirin 81 mg by mouth daily for anticoagulation (a process that prevents or reduces blood clotting). A review of Resident 111's History and Physical dated 9/26/2024, indicated the resident was to receive ongoing wound care, physical therapy, and oral antibiotics at the facility. (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 concurrent medication administration observation and interview on 10/3/2024 at 9:45 AM, Registered Nurse (RN) 2 was observed administering Septra DS, Pepcid, and Aspirin to Resident 111. Resident 111 refused to take Septra DS, Pepcid, and Aspirin. RN 2 was observed providing education to Resident 111 on what each medication was and their indication. Resident 111 was observed to continue to refuse to take the medication. RN 2 stated Resident 111 had a history of refusing to take his medication and this was not the first time Resident 111 refused to take medication. A review of Resident 111's care plan indicated there was no care plan developed for the resident's refusal to take Septra DS, Aspirin, and Pepcid. During a concurrent interview and record review on 10/3/2024 at 11:33 AM, Resident 111's care plan was reviewed with RN 2. RN 2 stated Resident 111 had a history of refusing medication and stated the resident refused to take medication the day before as well. RN 2 stated Resident 111 did not have a care plan to address the resident's refusal to take medication. RN 2 stated non-compliance and refusal of medications should be included in the resident's plan of care. RN 2 stated there could be a potential for the staff to not know about the care or needs of the resident which could lead to the resident not being educated about their medication. During an interview on 10/4/2024 at 12:24 PM, the Director of the Transitional Care Unit (DTCU) stated Resident 111 did not have a care plan for Resident 111's refusal of medications. The DTCU stated that care plans should be person-centered and address the resident's needs. b. A review of Resident 115's Admission Record (Face Sheet) indicated the facility admitted the resident on 9/19/2024, with diagnoses including gastrostomy tube (GT- a tube surgically inserted through the abdomen into the stomach for feeding, fluid, and medication administration), schizophrenia (a serious mental condition involving a breakdown in the relation between thought, emotion, and behavior, leading to faulty perception, bipolar disease (a mental health condition that causes extreme mood swings), and history of aphagia (a disorder that results from damage to portions of the brain that are responsible for language). A review of Resident 115's Patient Transfer Orders (Active Orders) dated 9/19/2024, indicated the resident was prescribed the following: -Lexapro (a medication used to treat depression [a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily activities of living]) 10 milligrams (mg - a unit of measure of mass) via GT feeding daily. -Zyprexa (a medication that can treat schizophrenia and bipolar disorder) 2.5 mg via GT feeding daily as Central Nervous System Agent (CNS-a type of drug that slows down brain activity, which causes the muscles to relax and calms and soothes a person). -Quetiapine (antipsychotic [medication used to treat mental illness]) tablet 25 mg via GT feeding three times a day as needed for agitation. A review of Resident 115's Care Plans dated 9/20/2024, indicated there were no care plans developed with goals or interventions for Resident 115's antipsychotic medication use. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 115's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 10/1/2024, indicated the resident's cognitive skills (brain's ability to think, remember, and express thoughts) for daily decision making was severely impaired (never / rarely made decisions). The MDS indicated Resident 115 did not have hallucinations (false perceptions, where you sense an object, person, or event even though it is not really there or didn't happen), and delusions. During a concurrent interview and record review on 10/4/2024 at 12:17 PM, with the Director of Transitional Care Unit (DTCU) Resident 115's care plans were reviewed. The DTCU stated the licensed staff did not develop a care plan to address Resident 115's diagnosis of depression, bipolar disease, and schizophrenia and his use of antipsychotic medications. The DTCU stated the potential outcome of not developing a person-centered care plan with goals and appropriate interventions was a potential for inadequate care and monitoring. 43851 c. A review of Resident 163's Facesheet report indicated the facility admitted the resident on 9/28/2024, with diagnoses including seizures (a sudden, uncontrolled burst of electrical activity in the brain that can cause changes in behavior, movements, feelings, and levels of consciousness) and diabetes mellitus (a disease of inadequate control of blood levels of glucose). A review of Resident 163's History & Physical (H&P) dated 9/28/2024, indicated the resident had interstitial lung disease (a large group of diseases that cause scarring of the lungs that can make it difficult to breathe and get enough oxygen into the bloodstream). A review of Resident 163's Active Orders dated 9/28/2024, indicated to administer oxygen (O2) via nasal cannula (NC - a device that delivers extra oxygen through a tube and into your nose) at 2 L/min (liters per minute) and to keep O2 saturation (measurement of oxygen saturation in the blood) greater than 92. A review of Resident 163's Care Plans, indicated there was no care plan developed with measurable goals and interventions to monitor the oxygen use via nasal cannula. During a concurrent observation and interview on 10/3/2024 at 11:30 AM, inside Resident 163's room, Resident 163 was observed sitting on the chair at the left side of his bed receiving oxygen via nasal cannula at 2 liters per minute. Resident 163 stated he was always using oxygen and without it he felt tired and short of breath, especially when walking around. Resident 163 stated he did not know if he would need oxygen when discharged home. During a concurrent interview and record review on 10/3/2024 at 12 PM, Resident 163's care plan was reviewed with Registered Nurse 2 (RN 2). RN 2 stated Resident 163's current care plans did not indicate that the resident received oxygen. RN 2 stated it should be added, especially if the goal was to go home without oxygen. RN 2 stated the care plan guided the staff on how to care for the resident and there was a potential risk for inadequate care of the resident. During a concurrent interview and record review on 10/3/2024 at 3 PM, Resident 163's care plan was reviewed with the DTCU. The DTCU stated the care plans did not reflect Resident 163's use of oxygen and It should indicate the management and goals for his oxygenation. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. A review of Resident 166's facesheet report indicated the facility admitted the resident on 9/26/2024, with a diagnoses including failure to thrive (a condition characterized by the gradual decline in physical or mental function, resulting in an overall decline in well-being). A review of Resident 163's Active Orders, dated 9/30/2024 indicated the following wound care orders: - LLE (left lower extremity) / left first / second toes - lesions (damaged or abnormal area of tissue that can occur anywhere in the body that can be caused by injury, infection, or disease) - paint with Betadine swab, keep open to air every day. -Right first toe / left medial (middle area) ankle / left plantar (sole) lateral (side) foot / left heel- lesions - paint with Betadine swab, keep open to air daily. - Left medial knee- resolving lesions - paint with Betadine moisten gauze, cover with Optifoam daily and as needed if soiled / displaced. During a concurrent interview and record review on 10/1/2024 at 1:05 PM, Resident 166's care plan was reviewed with Registered Nurse 1 (RN 1). RN 1 stated the care plan did not reflect the resident's wound care for lesions. RN 1 stated there was a potential risk to miss those kinds of treatments and may cause more harm to the resident and worsen the wounds. During a concurrent interview and record review on 10/3/2024 at 3:10 PM, Resident 166's care plan was reviewed with the DTCU. The DTCU stated the care plan did not reflect the resident's wound care for lesions and the care plan should indicate the goals for the resident throughout their stay. A review of the facility's policy and procedure titled, Patient Plan of Care, reviewed 6/24/24, indicated Each patient will have an individualized plan of care based on needs identified by patient assessment, reassessment, and results of diagnostic testing. Patient assessment will take into account patient's treatment goals and as appropriate physiological, psychosocial, and spiritual factors and patient discharge planning needs when creating the plan of care. Plan of care is based on patient's goals and time frames, settings, and services required to meet those goals. Based on goals established in patient's plan of care, staff evaluate the patient's progress. Plan of care, goals for treatment, and services are revised and based on patient's needs. Plan of care will be modified as appropriate. Registered Nurse (RN) will review plan of care with patient, family, and/or significant other upon initiation and once per shift. Evaluation of patient progress toward goals/outcomes and educational needs will be documented by all disciplines as appropriate. The following will be documented in the medical record: 1. Assessment and individualization of plan of care. Reassessment / modification of plan as needed 2. Review of plan with patient, family, and/or significant other 3. Progress/evaluation towards goals / outcomes.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 44309 Based on interview and record review, the facility failed to timely and accurately complete a discharge summary for two of four sampled residents (Resident 8 and Resident 9). For Resident 8, there was no discharge summary completed within 14 days of the resident being discharged . For Resident 9, the discharge summary did not include a final summary of the resident's status. These deficient practices caused an increased risk in the continuing care of the residents. Findings: a. A review of Resident 8's Facesheet Report indicated the facility admitted the resident on 7/1/2024 with diagnoses including chest pain. A review of the Physician's Order dated 7/5/2024, indicated Resident 8 was discharged to the acute hospital and was to be transferred to the telemetry unit (a hospital ward where patients are continuously monitored for their cardiac activity and other vital signs) for anemia and hyperkalemia treatment. A review of the Discharge Summary dated 10/2/2024, indicated Resident 8's discharge diagnoses were generalized muscle weakness and moderate risk for falls. The discharge summary indicated Resident 8 was discharged to telemetry. During a concurrent interview and record review on 10/4/2024 at 11:08 AM, Resident 8's discharge summary was reviewed with the Director of the Transitional Care Unit (DTCU). The DTCU stated Resident 8's discharge summary was dated 10/2/2024. The DTCU stated the discharge summary was completed late and indicated a discharge summary should be done within 14 days of the resident being discharged . The DTCU stated the discharge summary was to aid in communication between medical providers and promoted the continuation of care for the resident. The DTCU stated there was a potential for a gap in communication for Resident 8's care if the discharge summary not completed in a timely manner. b. A review of Resident 9's Admission Record (Face Sheet) indicated the facility admitted the resident on 7/8/2024, with diagnoses including right foot osteomyelitis (an infection in a bone), and Type II diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). A review of Resident 9's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 7/19/2024, indicated the resident's cognitive skills (brain's ability to think, remember, and express thoughts) for daily decision making was intact (decisions consistent and reliable). The MDS indicated Resident 9 required supervision for personal hygiene, upper and lower body dressing and putting on/taking off footwear. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 9's Transitional Care Unit (TCU) Discharge Summary dated 9/19/2024, completed by the resident's physician indicated the resident's discharge disposition was home with home health services. The discharge summary note indicated, Resident 9 ultimately opted to return home with home health to finish off antibiotics and wound care. He will need to follow up closely as outpatient with podiatry services and his primary care physician in one-two weeks. A review of Resident 9's Patient Transfer Orders (Active Orders) indicated there was no physician's order for Resident 9's discharge. During a concurrent interview and record review on 10/2/2024 at 2:34 PM with the facility's Infection Preventionist Nurse (IP), Resident 9's Physician's Orders were reviewed. The IP stated, There is no physician discharge order in Resident 9's medical records. The IP further stated, It is required to have an order for discharge. During a concurrent interview and record review on 10/2/2024 at 2:48 PM, with the facility's Director of Transitional Care Unit (DTCU), Resident 9's Physician's Orders and Interdisciplinary Progress Notes were reviewed. The DTCU stated there was no discharge order for Resident 9 in his medical record because Resident 9 left the facility Against Medical Advice (AMA) on 7/19/2024 at approximately 9 PM. The DTCU stated Resident 9 had a Peripherally Inserted Central Catheter (PICC Line- a thin, flexible tube that is inserted into a vein in the upper arm and is used to give intravenous fluids, blood transfusions, chemotherapy, and other drugs) and wound vac (a treatment that applies gentle suction to a wound to help it heal) for his wound management. However, there were no notes from licensed nurses regarding the reason why Resident 9 went home AMA or whether or not the PICC line and wound vac were removed prior to Resident 9's exit from the facility. The DTCU stated there was no signed AMA form available in Resident 9's medical records, that licensed staff were required to document a resident's condition prior to any discharge, and to include the type of education and instructions provided to the resident. The DTCU further stated Resident 9's Physician's discharge summary dated 7/19/2024 did not reflect the correct disposition of the resident's discharge. The DTCU stated Resident 9 was never discharged home with home health service from the facility, but he left the facility AMA. The DTCU stated the potential outcome of an incorrect discharge summary was the absence of necessary and vital information in the resident's medical record. During a concurrent interview and record review on 10/3/2024 at 10:37 AM, with Licensed Vocational Nurse 1 (LVN 1), Resident 9's Physician's discharge summary and Interdisciplinary Progress Notes were reviewed. LVN 1 stated, On 7/19/2024, I worked during the 7 AM-7 PM shift. At around 5:30 PM, Resident 9 called me and asked if he can be discharged . Normally, we contact the physicians and inform them about the resident's request to be discharged . I don't recall weather or not I called the physician to inform him about Resident 9's request to be discharged . If a resident wants to leave the facility Against Medical Advice (AMA), we notify the physician. Ideally, we want the physician to come to the resident's bedside and explain the risks of AMA. There is form for AMA that residents are required to sign before they leave. LVN 1 stated there was no documentation supporting that Resident 9 signed the AMA form or that the nurses removed his PICC line and wound vac. LVN 1 stated Resident 9's physician's discharge summary indicated that Resident 9 was discharged home with home health. LVN 1 stated, This is not an accurate discharge summary. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility's policy and procedure titled, Discharge of Patients, revised 9/28/2023, indicated all patients will have a physician's order prior to discharge. Discharge the patient in the computer utilizing correct discharge utilization. Document the following in the medical records: patient status, status of patient goals, and discharge time. The Physician and/or licensed nurse will complete the Discharge Instruction form, discharge orders will be transferred onto the Discharge Instructions form. Discharge reconciliation of medications will be performed per Medication Reconciliation policy. Any physician specific discharge instructions will be sent home with patient. For patients discharged from the Transitional Care Unit a copy of the summary of care will be given on discharge.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on observation, interview, and record review, the facility failed to ensure one of ten sampled residents (Residents 166) received care and treatment to promote healing of wounds, as ordered by the physician. This deficient practice caused an increased risk of worsening of the wounds and potential infection for Resident 166. Findings: A review of Resident 166's facesheet report indicated the resident was admitted to the facility on [DATE] with diagnoses including failure to thrive (a condition characterized by the gradual decline in physical or mental function, resulting in an overall decline in well-being). A review of Resident 163's Active Orders, dated 9/30/2024 indicated the following wound care orders: -Paint the wound on Left Lower Extremity (LLE), left first and second toe with Betadine swab, keep it open to air every day. -Paint the wound on right first toe, left medial (middle area) ankle, left plantar (sole), lateral(side) foot and left heel with Betadine swab, keep it open to air daily. - Paint the wound on left medial knee with Betadine moisten gauze, cover it with Optifoam daily and as needed if soiled or displaced. During a concurrent interview and record review on 10/1/2024 at 1:05 PM, Resident 166's active orders, Medication Administration Records (MAR), care plans and Interventions Flowsheet were reviewed with Registered Nurse 1 (RN 1). RN 1 stated there was no evidence of documentation that the wound care orders dated 9/30/2024 were carried out daily as ordered. RN 1 stated it was important to check and carry out the orders. RN 1 stated there was no care plan developed for Resident 166, including person centered goals and interventions for the resident's wound care. RN 1 stated if treatments were missed, it could cause more harm to the resident and worsen the wound. During a concurrent observation and interview with Resident 166 on 10/2/2024 at 2:20 PM, Resident 166 was observed lying on his bed with multiple wounds on both lower extremities. Resident 166 stated staff provided wound care about every other day. During a concurrent interview and record review on 10/3/2024 at 3:10 PM, Resident 166's active orders, MAR, care plans, and Interventions Flowsheet were reviewed with the Director of Transitional care Unit (DTCU). The DTCU stated, there was no evidence of documentation that the wound care orders dated 9/30/2024 were carried out daily as ordered. The DTCU stated, there was no care plan developed for Resident 166 that included person centered goals and interventions for the resident's wound care. The DTCU stated the care plan should indicate the goals for the resident throughout their stay. (continued on next page)

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Pih Health Good Samaritan Hospital D/P Snf	1225 Wilshire Blvd Los Angeles, CA 90017

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility's policy and procedure titled, Physician's Orders, dated 7/3/2023, indicated the Registered Nurse (RN) was responsible for coordination and implementation of diagnostic and therapeutic orders of medical staff members. A review of orders would be performed every shift. Routine orders were to be initiated within 24 hours or as soon as possible of being written. A review of facility's policy and procedure titled, Pressure Injury - Prevention and Treatment, dated 9/27/2023 indicated to document treatments, interventions, repositioning and patients response daily in the medical records.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 44309 Based on interview and record review, the facility failed to ensure one sampled resident(Resident 115), who was receiving nutrition by gastrostomy tube (GT- a flexible tube surgically inserted through the abdomen into the stomach for feeding, fluid, and medication administration), received appropriate care and services to prevent complications of enteral feeding (tube feeding, a way of delivering nutrition directly to your stomach or small intestine). This deficient practice had the potential to lead to the inadequate care of Resident 115 and place the resident at an increased risk for complications such as infection. Findings: A review of Resident 115's Admission Record (Face Sheet) indicated the facility admitted the resident on 9/19/2024, with diagnoses including gastrostomy tube, schizophrenia (a serious mental condition involving a breakdown in the relation between thought, emotion, and behavior, leading to faulty perception, bipolar disease (a mental health condition that causes extreme mood swings), and history of aphasia (a disorder that results from damage to portions of the brain that are responsible for language). A review of Resident 115's Patient Transfer Orders (Active Orders) dated 9/24/2024, indicated the resident was to receive tube feeding Pivot 1.5 (type of tube feeding) continuous at a rate of 45 millimeter (ml) / hour. A review of Resident 115's GT feeding care plan dated 9/20/2024 indicated there were not goals or person centered interventions included in the care plan. A review of Resident 115's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 10/1/2024, indicated the resident's cognitive skills (brain's ability to think, remember, express thoughts) for daily decision making was severely impaired (never/ rarely made decisions). The MDS indicated Resident 115 was receiving 51% or more of her total calories intake by tube feeding. During a concurrent interview and record review on 10/2/2024 at 11:25 AM, with the facility's Patient Safety Coordinator (PSC), Resident 115's Assessment and Intervention Flowsheets were reviewed. The PSC stated the licensed nurses were assessing, changing the site dressing, and monitoring residents with GT and documenting in the Assessment and Intervention Flowsheets. The PSC stated, I don't know how often the nurses are supposed to fill up this form. The PSC stated on 9/22, 9/27, and 9/30/2024, there was no documentation for Resident 115's GT insertion site skin monitoring, care, dressing changes, and no monitoring of the resident's feeding tolerance, feeding tube or bag changes or the residual volume. The PSC stated on 9/23/2024, there was no documentation for monitoring of GT insertion site skin, care and dressing change, or monitoring of the residual volume. The PSC further stated on 9/28/2024, there was no documentation of Resident 113's GT insertion site skin monitoring, care, and dressing changes. The PSC stated licensed nurses did not thoroughly complete the Assessment and Intervention Flowsheets for GT care. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/2/2024 at 12 PM, with the Director of Transitional Care Unit (DTCU), Resident 115's Assessment and Intervention Flowsheets and care plans were reviewed. The DTSC stated licensed staff were required to change the dressing for GT insertion site every 24 hours and as needed. The DTCU stated GT care and monitoring interventions do not require a physician order and they are standard nursing procedures. The interventions for GT care plan are documented in GT care flowsheet. Licensed staff did not completely document the care and monitoring they performed for Resident 115's GT and the flowsheets are missing documentation. When it is not documented, it is not done. The DTCU stated the potential outcome of not providing care and appropriate services for GT insertion site was complications such as infection. A review of the facility's policy and procedure titled, Enteral Feeding in Adult Patients, reviewed 7/3/2023, indicated enterostomy site should be evaluated for patency prior to initiating feeding by visually assessing the integrity of the feeding tube and ports, assessing the skin surrounding the stoma, and manipulating the enteral tube to ensure bumpers are properly positioned.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 44309 Based on interview and record review, the facility failed to ensure two of five sampled residents (Residents 113 and 115) were free from unnecessary use of psychotropic drugs (any medication capable of affecting the mind, emotions, and behavior) in accordance with the facility policy and procedure. For Resident 115, there was no measurable target behaviors related to the use of three antipsychotic medications. For Resident 113, there was no measurable target behaviors related to the use of two antidepressant medications. These deficient practices had the potential to place Resident 113 and Resident 115 at risk for significant adverse consequence (unwanted, uncomfortable, or dangerous effects that a drug may have) from the use of unnecessary psychotropic drug, which could result to impairment or decline in the residents' mental, physical condition, functional, and psychosocial status. Findings: a. A review of Resident 115's Admission Record (Face Sheet) indicated the facility admitted the resident on 9/19/2024, with diagnoses including gastrostomy tube (GT- a tube surgically inserted through the abdomen into the stomach for feeding, fluid, and medication administration), schizophrenia, bipolar disease, and history of aphasia (a disorder that results from damage to portions of the brain that are responsible for language). A review of the Patient Transfer Orders (Active Orders) dated 9/19/2024, indicated Resident 115 was prescribed the following: -Lexapro (medication used to treat depression [a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily activities of living]), 10 milligrams (mg-a unit of measure of mass) via GT feeding daily as antidepressant (medication used to cure depression). -Zyprexa (a medication that can treat schizophrenia [a disorder that affects a person's ability to think, feel, and behave clearly], 2.5 mg via GT feeding daily as Central Nervous System Agent (CNS-a type of drug that slows down brain activity, which causes the muscles to relax and calms and soothes a person). -Quetiapine (antipsychotic [medication used to treat mental illness]), tablet 25 mg via GT feeding three times a day as needed for agitation. A review of Resident 115's Care Plans dated 9/20/2024, indicated there was no care plan developed with goals or interventions for antipsychotic medication use. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 115's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 10/1/2024, indicated the resident's cognitive skills (brain's ability to think, remember, express thoughts) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 115 did not have hallucinations (false perceptions, where you sense an object, person, or event even though it is not really there or didn't happen), and delusions. During a concurrent interview and record review on 10/2/2024 at 1:46 PM, with the Director of Transitional Care Unit (DTCU), Resident 115's physician's orders were reviewed. The DTCU stated, Resident 115 was prescribed Lexapro for depression. Lexapro is one of Resident 115's home medications and the administration is being continued in the facility. The DTCU stated there was no order for a specific targeted measurable behavior related to use of Lexapro for Resident 115 and that there were no orders for monitoring for a specific targeted measurable behavior related to use of Quetiapine and Zyprexa. The DTCU stated the potential outcome of not monitoring residents for the specific targeted measurable behavior related to their use of antipsychotic medications was the inability to evaluate the effectiveness of the medication administered. b. A review of Resident 113's Admission Record indicated the facility admitted the resident on 9/30/2024, with diagnoses including uncontrolled Type II diabetes mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), infected diabetic ulcer (an open sore or wound that occurs patients with diabetes) right foot, and psych disorder (a broad range of problems that disturb a person's thoughts, feelings, behavior or mood). A review of Resident 113's Patient Transfer Orders (Active Orders) dated 10/1/2024, indicated the resident was prescribed Wellbutrin XL 150 mg by mouth daily for depression and Prozac 40 mg by mouth daily for depression. During a concurrent interview and record review on 10/4/2024 at 12:25 PM, with DTCU, the Physician's Orders were reviewed for Resident 113. The DTCU stated Resident 113 did not have orders for monitoring a specific targeted measurable behavior related to the resident's use of Prozac and Wellbutrin. The DTCU stated the potential outcome of not monitoring residents for the specific targeted measurable behavior related to their use of antipsychotic medications was the inability to evaluate the effectiveness of the medication administered. A review of the facility's Policy & Procedure (P&P) titled, Psychotherapeutic Medications, dated 7/3/2024, indicated prior to residents receiving psychotherapeutic drugs, consent will be obtained. Monitoring for side effects of prescribed medications for symptom management will be documented in medical record. Each psychotherapeutic medication will be ordered with indication for use by physician.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 43851 Based on interview and record review, the facility failed to submit their Payroll Based Journal (PBJ, information of the provider's daily staffing hours for the appropriate care of the residents) report to Center for Medicare Services (CMS) in a complete and accurate manner. This deficient practice prevented the provision of complete and accurate direct care staffing information to the public. Findings: A review of the CMS PBJ Staffing Report indicated during the first fiscal quarter of 2024 dated 10/1/2023 to 12/31/2023, there was excessively low weekend staffing data triggered. During the second fiscal quarter of 2024 dated 1/1/24 to 3/31/2024, the PBJ report indicated no Registered Nurse (RN) hours were triggered (four or more days within the quarter with no RN hours). The third fiscal quarter of 2024 dated 4/1/2024 to 6/30/2024, indicated one Star Staffing Rating and excessively low weekend staffing were triggered. A review of the CMS Submission Report for the first fiscal quarter dated 2/13/2024, indicated the facility submitted 86 employee records and 1840 total staffing hour records. The report indicated CMS received matching staffing records. The report indicated XML contained multiple staffing records for the sample employee id, job code, pay type and date. Action: Review staffing records to ensure the information is correct. The validation report only validates whether or not the data submitted was received successfully; however, it does not reflect the accuracy or completeness of the facility's data. A review of the CMS Submission Report for the second fiscal quarter dated 5/13/2024, indicated the facility submitted 95 employee records and 1804 total staffing hour records. The report indicated CMS received matching staffing records. The report indicated XML contained multiple staffing records for the sample employee id, job code, pay type and date. Action: Review staffing records to ensure the information is correct. The validation report only validates whether or not the data submitted was received successfully; however, it does not reflect the accuracy or completeness of the facility's data. A review of the CMS Submission Report for the third fiscal quarter dated 8/8/2024, indicated the facility submitted 133 employee records and 2056 total staffing hour records. The report indicated CMS received matching staffing records. The report indicated XML contained multiple staffing records for the sample employee id, job code, pay type and date. Action: Review staffing records to ensure the information is correct. The validation report only validates whether or not the data submitted was received successfully; however, it does not reflect the accuracy or completeness of the facility's data. (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on 10/4/2024 at 9:04 AM, the PBJ Staffing Report was reviewed with the Director of the Transitional Care Unit (DTCU). The DTCU stated staffing at the facility had been good and she did not understand why excessive low weekend staffing and no RN hours were triggered in the PBJ report. The DTCU stated the facility always had at least 1 RN on every shift. The DTCU stated the facility was supported by the General Acute Care Hospital (GACH) 1's staffing office so if needed the staffing office would send float nurses or registry nurses to cover. The DTCU further stated the information reported on the PBJ Staffing Data Report was inaccurate. During a telephone interview on 10/4/2024 at 9:15 AM, the Director of Strategic Partnerships (DSP) stated they had the responsibility of submitting the facility's PBJ quarterly. The DSP stated based on their knowledge there was no delay in submitting the PBJ reports and the files that were submitted in the PBJ looked fine. The DSP stated the files submitted to CMS for the PBJ did not show any issues with staffing and they did not know why the PBJ was triggered for excessive low weekend staffing and no RN hours. The DSP further stated the information reported on the PBJ Staffing Data Report must be inaccurate. A review of the CMS Electronic Staffing Data Submission Payroll-Based Journal Long-Term Care Facility Policy Manual Version 2.6 dated 06/2022, indicated Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. Submission requirements, the facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); Resident census data; and Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility or is engaged by the facility under contract or through an agency. Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. Submission schedule, the facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. A review of CMS' Staffing Data PBJ Submission website (https://www.cms.gov/medicare/quality/nursing-home-improvement/staffing-data-submission) modified 9/10/2024, indicated The Centers for Medicare & Medicaid Services (CMS) has long identified staffing as one of the vital components of a nursing home's ability to provide quality care. CMS has utilized staffing data for a myriad of purposes in an effort to more accurately and effectively gauge its impact on quality of care in nursing homes. We post staffing information on the CMS Nursing Home Compare website, and it is used in the Nursing Home Five Star Quality Rating System to help consumers understand the level and differences of staffing in nursing homes. CMS has developed a system for facilities to submit staffing information - Payroll Based Journal (PBJ). This system allows staffing information to be collected on a regular and more frequent basis than previously collected. It is auditable to ensure accuracy.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 43851 Based on observation, interview, and record review, the facility failed to implement infection control measures for one of 10 sampled residents (Resident 63). For Resident 63, the intravenous catheter (IV, a soft, flexible tube placed inside a vein, usually in the hand or arm. A medical technique that administers medication, fluids, and/or nutrients directly into a person's vein) was not discontinued / removed when clinically indicated. This deficient practice caused an increased risk to infection control issues and the potential of the resident experiencing phlebitis (inflammation of the vein). Findings: A review of Resident 63's Facesheet Report indicated the facility admitted the resident on 9/18/2024 with a diagnoses including failure to thrive (state of decline that may include weight loss, decreased appetite, poor nutrition, inactivity, and moderate protein-calorie malnutrition [lack of proper nutrition)]. A review of Resident 63's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 9/30/2024, indicated the resident was cognitively intact (ability to think, remember, express thoughts), was independent with eating, and required supervision or touching assistance for oral and personal hygiene. The MDS indicated Resident 63 required partial / moderate assistance for toileting hygiene and had IV access while being a resident at the facility. During an observation on 10/1/2024 at 10:08 AM, Resident 63 was observed lying in bed. Resident 63 was observed with an IV in their left arm which was dated 9/23/2024. Resident 63's skin was observed a pinkish red color with dried blood surrounding the IV site. During a concurrent observation and interview on 10/1/2024 at 10:30 AM, Resident 63's IV to the left arm was observed with Registered Nurse (RN) 3. RN 3 stated Resident 63's IV needed to be changed and should be changed when it was not working or it could not be flushed, when its red or pink in color, and every three days. RN 3 stated there was a potential for infection control issues if Resident 63's IV was not changed when needed. During an interview on 10/4/2024 at 12:24 PM, the Director of the Transitional Care Unit (DTCU) stated a resident's IV should be changed if it was not working, was occluded, or if the resident was having redness around the IV site. The DTCU stated there was a potential for the resident to have phlebitis if the IV was not changed as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Intravenous Therapy of Adults and Pediatrics-Peripheral and Central - E.87200.307, revised 7/3/2024, indicated PIV site changes are to be performed only as clinically warranted based on integrity and patency of the site. PIV site care and maintenance: a. All IV sites will be changed only as clinically warranted based on integrity and patency of the site and labeled with initiation date and time. PIV dressing is to be changed when it becomes damp, loose, soiled, or if the patient develops problems at the site that requires further inspection. IV sites will be assessed at a minimum of every 4 hours for signs of phlebitis, infiltration, or infection including pain, redness, swelling, induration, or disruption of flow. If gauze dressing is being utilized, assess for phlebitis and infection at time of dressing change. If phlebitis or infiltration exists, the catheter will be removed, and extremity elevated.