STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056487	A. Building B. Wing	03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rio Hondo Subacute & Nursing Center	273 E Beverly Boulevard Montebello, CA 90640

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 40773 Based on observation, interview, and record reviews, the facility staff failed to sit and be at eye level while providing feeding assistance to one of one sampled residents (Resident 138) during dining, in accordance with the facility policy. This deficient practice had the potential for Resident 138 not being respected in a manner to maintain dignity. Findings: A review of Resident 138's Admission Record indicated an admission to the facility on [DATE] with diagnoses of hemiplegia (paralysis of the muscles of the lower face, arm, and leg on one side of the body) and hemiparesis (weakness or inability to move on one side of the body), dysphagia (difficulty swallowing), and emphysema (a lung condition that causes shortness of breath). A review of Resident 138's History and Physical dated 1/20/23 indicated Resident 138 had fluctuating capacity to understand and make decisions. A review of Resident 138's Minimum Data Set (MDS, a standardized assessment and care planning screening tool), dated 1/13/23, indicated Resident 138 required extensive assistance (staff provide weight bearing support) with one person assist with bed mobility, dressing, eating, toilet use, and personal hygiene. A review of Resident 138's active Order Summary Report for 3/2023, indicated an order for dysphagia puree texture (a pudding-like texture that is smooth, blended, or pureed) thick liquids-nectar consistency (thicker than water, fall slowly from a spoon, and are sipped through a straw or from a cup), double portion, three times a day, started 8/20/22. During a dining observation in Resident 138's room on 3/14/23 at 1:16PM, Resident 138 seated in bed and certified nurse assistant (CNA1) was observed standing above Resident 138 and providing feeding assistance. During an interview on 3/14/23 at 1:17PM, CNA2 stated while assisting with feeding, staff should be seated at eye level for better communication and for one-to-one time with the resident. CNA2 acknowledged standing up and stated should have sat down while assisting Resident 138 with feeding. (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 - Few	During an interview on 3/15/23 at 8:42AM, Resident 138 stated staff do not always sit when providing feeding assistance, and when Resident 138 was assisted during dining and staff was seated, Resident 138 stated being able to see who was actually feeding Resident 138. During an interview on 3/15/23 at 8:54AM, licensed vocational nurse (LVN4) stated positioning of staff during dining assistance should be at eye level with the resident, and seated on a chair. LVN4 stated staff should not stand above the resident, and must always obtain a chair. During an interview on 3/16/23 at 7:47AM, Director of Staff Development (DSD) stated while providing dining assistance, staff should be seated at eye level with the resident for dignity issues. DSD stated it was important to seat and not to be able to view how the resident was eating and be able to communicate with the resident. DSD stated when staff are standing while providing feeding assistance, the resident may feel inferior, belittled, and hurried. A review of the facility's policy titled Dignity, revised 02/2020, indicated Residents are treated with dignity and respect at all times. A review of the facility's policy titled, Assistance with Meals, 03/2022, indicated Resident who cannot feed themselves will be fed with attention and safety, comfort, and dignity, for example, Not standing over residents while assisting them with meals.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40773 Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 65) was informed by the physician of the risks and benefits of the proposed care, treatment, and alternatives for the use of psychotropic drug (any medication capable of affecting the mind, emotions, and behavior) as indicated on the facility policy and procedures. This deficient practice had the potential to violate Resident 65's right to be informed and to choose the type of care or treatment to be received, or alternatives the resident or responsible party preferred. Findings: During concurrent observation and interview in Resident 65s room on 3/13/23 at 12:29PM, Resident 65 was observed seated on his wheelchair beside his bed. Resident 65 was well groomed and had personal belongings organized in his room on a dresser and in boxes. Resident 65 stated not being able to sleep during the nighttime and sleeps more during the day. A review of Resident 65's Admission Record indicated an initial admission to the facility on [DATE], and readmission on 1/20/23 with diagnoses of hypertension (high blood pressure), diabetes (high blood sugar) and depression (a constant feeling of sadness and loss of interest, which stops you doing your normal activities). A review of Resident 65's Minimum Data Set (MDS, a standardized assessment and care planning screening tool) dated 2/3/23 indicated Resident 65 had no cognitive (person's ability to think, learn, remember, use judgement, and make decisions) impairment. The MDS indicated Resident 65 required extensive assistance (staff provide weight bearing support) with one person assist with bed mobility, dressing, toilet use, and personal hygiene. A review of Resident 65's Physician order, dated 6/19/21 indicated Lexapro (an antidepressant) 20 milligrams (mg, a unit of measurement) by mouth daily for depression. A review of Resident 65's Psychotropic Medication Administration Informed Consent, dated 6/19/21 indicated an order for Lexapro 20 mg by mouth daily for depression. The Consent was not signed by Resident 65 or Responsible Party. During a concurrent interview and records review of Resident 65's Psychotropic Medication Administration Informed Consent on 3/16/23 at 9:23AM, the Assistant Director of Nurse (ADON) acknowledged the Consent dated 6/19/21 was not signed by Resident 65. A review of the facility's Policy and Procedure titled, Psychoactive Drug Management, revised 9/20/22, indicated informed consent must be obtained from the resident or responsible party when processing a new order or an increase in psychoactive drugs. The policy indicated licensed nurses verifies with the resident that informed consent had been obtained by the attending physician prior to administering the medication ordered.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40773 Based on observation, interview and record review, the facility failed to accommodate the needs for 5 out of 6 sampled Residents (48, 61, 135, 160, and 163) by: 1. Failed to ensure a clock was provided to Resident 135. 2. Failed to ensure call light (a device used by residents to signal his or her need for assistance) switch was functioning and within reach of Resident 48, 61, 160 and 163 in accordance with the facility's policy and procedure. These deficient practices had the potential for Residents 48, 61, 160, and 163 not able to call the facility staff to ask for help or assistance specially during emergency; for Resident 135 to not be oriented to the time of the day. A review of Resident 135's Admission Record indicated an initial admission to the facility on [DATE], and readmission on 1/19/23 with diagnoses of paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease), urinary tract infection (an infection in any part of the urinary system), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). A review of Resident 135's Minimum Data Set (MDS: a standardized assessment and care planning screening tool) dated 2/28/23 indicated Resident 138 had no cognitive impairment. The MDS indicated, Resident 138 required extensive assistance (staff provide weight bearing support) with one person assist with bed mobility, toilet use, and personal hygiene. The MDS indicated, Resident 138 was totally dependent (full staff support) with dressing and required supervision with eating. A review of Resident 135's Care Plan for cognitions indicated Resident 138 was alert and oriented and communicated well. The Care Plan goal indicated daily routines and preferences would be accommodated. During an observation in Resident 135's room on 3/14/23 at 9:18 AM, Resident 135 was observed laying in bed and watching on tablet (a wireless portable personal computer) located on her bedside table. There was no clock observed in Resident 135's room. During an interview on 3/14/23 at 9:19 AM, Resident 135 stated she wanted a clock in her room so that the time could be easily accessible rather than Resident 135 having to find her tablet and/or cellphone to check the time. Resident 135 stated when she moved to her room a week ago, there was no clock. During a concurrent observation in Resident 135's room and interview on 3/15/23 at 8:30 AM, CNA 1 stated there was no clock in Resident 135's room and that there should always be a clock in each resident's room. CNA1 stated Resident 135's room was remodeled prior to Resident 135 being transferred into the room and that the clock should have been set up prior to Resident 135 moving to the room. CNA 1 stated it was important for Resident 135 to have a clock to be able to see the time easily. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/16/23 at 7:41 AM, the Director of Staff Development (DSD) stated a clock was a basic need for the resident and should be placed in Resident 135's room for reality orientation. The DSD stated clocks in rooms were important, regardless of mental status or medical diagnoses. The DSD stated clock could limit confusion at times, therefore a clock was utilized to keep residents oriented to the time. During an interview on 3/16/23 at 10:19 AM, the Assistant Director of Nurse (ADON) stated clocks were utilized for resident mentation, so residents could plan their day accordingly. The ADON stated clocks were utilized regardless of mental status and that every resident should be provided a clock in their room. A review of the facility's policy and procedure titled Homelike Environment, revised February 2021, indicated residents are provided with a safe, clean, comfortable homelike environment. The policy indicated staff would provide person- centered care that emphasized the residents comfort, independence and personal needs and preferences. 42878 2. a. A review of Resident 160's Admission Record indicated resident was originally admitted to the facility on [DATE] and then readmitted on [DATE] with diagnosis that included dysphagia (difficulty swallowing foods or liquids) and type 2 diabetes mellitus (a disease in which your blood glucose, or blood sugar, levels are too high). A review of Resident 160's History and Physical (H&P) dated 2/10/23 indicated Resident 160 has fluctuating capacity to understand and make decisions. A review of the Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 01/10/23, indicated Resident 160 was severely impaired with cognitive skills for daily decision making (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 160 required one- person total dependance (full staff performance every time) with bed mobility, dressing, eating, toilet use and personal hygiene. During an observation in Resident 160's room on 03/13/23 at 10:20 AM Resident 160 was sitting up in bed stating I need help I cannot call nurse. Resident 160's call light was observed hanging on intravenous pole (IV)pole next to bed over g-tube feeding bottle. During a concurrent interview and observation in Resident 160's room with Licensed Vocational Nurse (LVN4) on 03/13/23 at 10:24 AM, LVN stated, Resident 160's call light was hanging by the IV pole and was not withing arm reach of the resident LVN 4 stated the call light should always be within resident's reach to prevent an accident or injury to a resident trying to call for assistance. During an interview on 03/15/23 at 4:00 PM with Director of Nursing, DON stated it is the facility's practice to always leave the call light within residents' reach. The DON stated it is important for all residents to have their call light within reach to get assistance from the staff when in distress, or when resident's needs assistance to prevent accident and to ensure we meet the residents' needs. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	44114 2.b A review of the Resident's 163's Admission Record (a document that gives a resident's information at a quick glance) indicated Resident 163 was admitted on [DATE] with the diagnoses that included hemiplegia (paralysis on one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), and dysphagia (difficulty swallowing). A review of Resident's 163's History and Physical Examination dated 1/24/23 indicates Resident 163 has fluctuating capacity to understand and make decisions. A review of Resident's 163's Minimum Data Set (MDS - a comprehensive assessment and care-screening tool), dated 1/16/23, indicated Resident 163 required total assistance from one facility staff when dressing, toileting, and extensive assistance from one facility staff during eating and bathing. A review of Residents 163's care plan (documentation of information that easily described the services, care and support being given to the patient) indicated, Resident 163 requires assistance/is dependent for activities of daily living (ADL's), related to limited mobility (a disability that affects movement ranging from gross motor skills, such as walking, to fine motor movement involving manipulation of objects by hand). During an observation in Resident 163's room and interview on 3/13/23 at 10:39 AM Resident 163 was observed awake in bed. Resident 163 stated do not know where the call is, I yell out nurse and they come. Resident 163 stated, I don't mind yelling for help that is how I have always done things. During a concurrent interview and observation in Residents 163's room on 3/13/23 at 10:43 AM, Resident's 163 call light was observed on the back of Resident's 163's headboard. Certified nurse assistant 1 (CNA1) stated, the call light was behind the resident headboard and the resident is not able to reach the call light and it should be within the resident's reach. CNA 1 stated, the importance of the call light within resident's reach is so they notify staff of basic needs like food, water, toileting (the act of assisting a dependent patient with his/her elimination needs), emergency, CNA 1 also stated, call light is not within reach, they would need to get up on their own and will put resident at risk for accidents or falls. During a concurrent interview and observation in Residents 163's room on 3/13/23 at 10:46 AM Licensed Vocational Nurse 1 (LVN 1) stated the call light should be within reach per facility's policy and procedure and the purpose is so they can inform staff when residents need anything; such as water, toileting, pain medication, repositioning (the movement of residents from one position to another in an effort to alleviate or redistribute any pressure exerted on the body tissues), and for safety so residents do not fall. During an interview with the Director of Nursing (DON), on 3/15/23 at 10:00 AM DON stated, the residents should be able to always reach the call light when they are in bed or sitting. The DON stated the purpose is for resident safety and for residents to have ability to call staff for help when needed. 46779 (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.c A review of Resident 61's Admission Record indicated the facility admitted Resident 61, on 11/5/22 with diagnoses that included type II diabetes mellitus (a disease that affects how the body uses blood sugar) and dementia (a general term to describe a group of symptoms related to loss of memory and judgment). A review of Resident 61's MDS, dated [DATE], indicated Resident 61 had severely impaired memory and cognition (ability to think and reason). Resident 61 required supervision (oversight, encouragement, or cueing) with transferring and eating, and limited assistance (resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance) with dressing, toilet use and personal hygiene. During a concurrent observation and interview, on 3/13/23 at 10:45 AM, Resident 61 was closing her eyes and lying on the bed calmly. Resident 61's call light was on the floor and missing the pressing button on the call light. Resident 61 stated she did not know where call light was. Resident 61 shook her head when showed her where the call light was and asked if she could reach it on the floor. During a concurrent observation and interview, on 3/13/23 at 10:48 AM, Licensed Vocational Nurse (LVN) 7 stated the call light was on the floor and was missing the pressing button on the call light. LVN 7 stated the call light was broken and she did know for how long the call light had been broken. LVN 7 stated Resident 61 could not use the call light for assistance if needed and it was important to always keep the call light functioning. During a concurrent observation and interview, on 3/13/23 at 10:53 AM, the Director of Maintenance (DM) stated he was not aware of Resident 61's call light was broken until today. DM stated he would randomly check on four call lights each wing and in the shower room every day. DM stated the nurses would call and page him if there was a broken call light and he would come immediately to fix it. DM stated to maintain a functioning call light was very important because of the residents' safety. During an interview on 3/13/23 at 3:48 PM, Registered Nurse (RN 4) stated the call lights should be always functioning so the residents could ask for assistance and ensure their safety. During a concurrent interview and record review, on 3/15/23 at 11:15 AM, with DM, Call Light Logs, dated 2/23, indicated DM last checked on the call light in Resident 61's room on 2/16/23. DM stated he did not check on the call light in Resident 61's room after 2/16/23 or receive any report on the broken call light for Resident 61 until 3/13/23 in the morning. 46919 2d. A review of Resident 48's Admission Record indicated Resident 48 was initially admitted on [DATE] and readmitted on [DATE] with diagnoses that included schizophrenia (a mental disorder that affects the way a person thinks, acts, expresses emotions, perceives reality, and relates to others), obsessive-compulsive disorder, nocturnal enuresis (involuntary urination at night while sleeping), and restlessness and agitation. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 48's MDS, dated [DATE], indicated Resident 48 had moderately impaired cognition and required limited assistance (resident involved in activity; staff guided maneuvering of limbs or other non-weight bearing assistance) with one-person physical assist with bed mobility, transfer, locomotion (ability to move from one place to another) on/off unit, dressing, eating, and personal hygiene. Resident 48 required extensive assistance (resident involved in activity, staff provide weight-bearing support) with one-person physical assist with toilet use. During an observation on 3/14/23, at 8:21 AM, Resident 48 was awake and alert while watching television. Resident 48 was wearing his hospital gown and was restless in bed. In a concurrent interview, Resident stated he wanted to change out of his hospital gown so he can smoke a cigarette. Resident 48 stated he was unable to ask assistance from staff because he cannot locate his call light. Resident 48 stated his call light is usually attached to the wall but this morning it was not there. During and observation on 3/14/23, at 8:25 AM, CNA 4 entered Resident 48's room and found Resident 48's call light on the floor behind Resident 48's bedside table. CNA 1 immediately placed the call light back on Resident 48's bed. During an interview with CNA 4 on 3/14/23, at 8:35 AM, CNA 4 confirmed Resident 48's call light was found on the floor behind the bedside table. CNA 4 stated today is his first day working at the facility and does know why the call light was there. CNA 4 stated that the call light needs to be within the resident's reach so the resident can get assistance and ask for help. CNA 4 stated if resident is unable to get help, the resident can fall and end up in the hospital. During an interview with Treatment Nurse 1 (TN 1) on 3/14/23, at 8:47 AM, TN 1 stated it is important for the resident's call light to be within the reach so the resident can call staff for help. TN 1 explained if the resident has no access to call light, the resident will not be able to get assistance from staff in case of a fall or accident. TN 1 stated the call light should be clipped to the bedsheet or attached to the side of the bed. A record review of the facility's policy and procedure, revised on September 2022, titled Answering the Call Light, indicated to ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor. A record review of the facility's policy and procedure, revised on 1/26/21, titled Call Lights, indicated residents will have a call light or alternative communication device withing their reach at all times when unattended.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42334 The facility failed to provide a home like environment for two of twenty residents sampled (Residents 90 and 431) by: 1. Resident 90's bedside table (nightstand) first drawer was missing a handle. 2. Resident 431's decorative wood molding on the wall was partially missing and partially falling off the wall. This deficiency can negatively affect the resident's quality of life. Findings: 1. A review of Resident 90's admission record indicated, the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including, but not limited to, diabetes (a chronic condition that affects the way the body processes sugar), dementia (a condition characterized by progressive or persistent loss of intellectual functioning) and heart disease (heart conditions that include diseased vessels, structural problems, and blood clots). A review of Resident 90's history and physical dated 5/6/22 indicated, the resident had fluctuating capacity to understand and make decisions. A review of Resident 90's comprehensive admission Minimum Data Set (MDS - a standardized assessment and screening tool) dated 12/15/22, indicated the resident had impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making with difficulties in memory and recall. The MDS indicated the resident was extensively dependent on staff for activities of daily living (ADLs - term used in healthcare to refer to daily self-care activities) including dressing, toilet use and personal hygiene, but was able to eat with limited assistance. During an interview and observation on 3/13/23 at 9:09 AM, Resident 90's bedside table- first drawer handle was not attached and was sitting on top of the bedside table. Resident 90 stated, it was broken for as long as she can remember. Resident 90 further stated, she wanted to be able to check her bedside table drawer for her belongings but was not able to because it is broken. During an observation in Resident 90's room on 3/15/23 at 12:16 PM, Resident 90's bedside table first drawer is still missing the handle or broken. During an interview on 3/16/23 at 11:50 AM, Director of Maintenance (DM) stated the Resident 90's bedside table- first drawer's handle was not reported to him and that it should have been so he could fix it. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of Resident 431's admission record indicated, the resident was originally admitted to the facility on [DATE] with diagnoses including, but not limited to, dementia, generalized weakness (a feeling of weakness in the whole body), and malnutrition (lack of proper nutrition, caused by not having enough to eat). During an observation in Resident 431's room on 03/16/23 at 11:04 AM, Resident 431's wall behind his bed had a decorative wood molding that was partially missing and partially falling off. The decorative molding on the wall that was missing and partially falling off was halfway from above the ceiling and wood molding was positioned horizontally. During an interview and observation in Resident 431's room on 3/16/23 at 12:14 PM, DM stated, the decorative molding on the wall was falling off and missing some areas and should be fixed. DM stated, it was not reported to him, and it should be fixed to ensure to provide a clean and home like environment for the resident. A review of the facility's policy titled, Homelike Environment, dated 2/21, indicated, Residents are provided with a safe, clean, comfortable and homelike environment, and that, the facility staff and management maximizes the characteristics of the facility that reflect a homelike setting.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 47331 Based on interview and record review, the facility failed to notify the ombudsman of a facility-initiated transfer (transfer not initiated by the resident) for one of three residents (Resident 283) when Resident 283 was transferred to the acute care hospital on 2/26/23. FINDINGS: A review of the Admission Record indicated Resident 283 was initially admitted to the facility, on 2/23/23, for diagnoses that included severe sepsis with septic shock (a blood infection that causes organ failure and low blood pressure), pneumonia (lung infection), type 2 diabetes (condition where the body can't control blood sugar levels on its own), subarachnoid hemorrhage (bleeding in the brain) and dependence on respirator (breathing machine). The record indicated on 2/26/23, Resident 283 was transferred to an acute care hospital for a change of condition. During an interview, on 3/15/23 at 2:43 PM, Licensed Vocational Nurse (LVN 12) stated Resident 283 was sent to the hospital on 2/26/23 for shortness of breath, labored breathing, fever, and increased heart rate. LVN 12 stated Resident 283 was diagnosed with an infection and received antibiotics. LVN 12 stated the family was notified when a resident transferred to the hospital. During an interview, on 3/15/23, at 2:50 PM, Registered Nurse (RN 2) stated the persons on the resident's emergency contact sheet were notified when a resident transferred to the hospital. RN 2 stated the ombudsman was not called. During an interview on 3/15/23, at 3:00 PM, the Director of Nursing (DON) stated there was transfer documentation in the computer for the nurses to complete. The DON stated notifications were made to the resident representatives and the doctor and that's it. The DON stated all the necessary notifications were in the eINTERACT Transfer Form online and was completed by nursing staff. During an interview on 3/16/23, at 9:58 AM, the Medical Records Technician (MRT) stated the ombudsman was only notified when the resident gets discharged . The ombudsman was not notified when residents transferred to the hospital. During an interview on 3/16/23, at 1:30 PM, the DON stated ombudsman was not notified for hospital transfers and was not aware that the notification needed to be made. The DON stated they only contacted the ombudsman for discharges but not for transfers. During a review of Resident 283's eINTERACT Transfer Form V5, dated 2/26/23, it did not indicate the ombudman was notified of the transfer to the hospital on 2/26/23 and there was no area designated for ombudsman notification on the electronic form. During a review of the eINTERACT Change in Condition Evaluation V5.2, dated 2/26/23, indicated there were sections to complete for resident representative notification and doctor notification. There were no sections for ombudsman notification. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled Discharging a Resident without a Physician's Approval, dated October 2012, indicated a doctor's order is needed for all discharges unless a resident is leaving against medical advice. The policy did not address notifications to the ombudsman. During a review of the facility's policy and procedure titled Transfer or Discharge, Preparing a Resident for, dated December 2016, indicated the business office notifies nursing services of the discharge or transfer. The policy did not indicate notifications to doctors or the ombudsman.

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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** 41379 Based on observation, interview, and record review, the facility failed to accurately assess seven of 40 sampled residents' (Residents 120, 22, 106, and 81) status. The facility failed to ensure: 1. Resident 120 's Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated 9/9/22 was accurately assessed and coded for functional range of motion (ROM, full movement potential of a joint) limitation. Resident 120's MDS dated [DATE] was accurately assessed and coded for Restorative Nursing Programs (RNA, nursing aide program that help residents to maintain their function and joint mobility). 2. Resident 22's MDS dated [DATE] was accurately assessed and coded for Restorative Nursing Programs. 3. Resident 106's MDS dated [DATE] was accurately assessed and coded for functional range of motion limitation and for Restorative Nursing Programs. 4. Resident 81's MDS dated [DATE] was accurately assessed and coded for Restorative Nursing Programs. The deficient practices had the potential to cause inaccurate care planning and inadequate provision of services for Residents 120, 22, 106, and 81. Findings: 1. A review of Resident 120's Admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including acute and chronic respiratory failure (any condition that affects breathing function and result in lungs not functioning properly), contracture (loss of motion of a joint) of muscle multiple sites, and functional quadriplegia (weakness or paralysis to all four extremities). A review of Resident 120's physician's order summary report indicated the following: a. RNA to provide passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises to both lower extremities (BLE, hip, knee, ankle, foot) five (5) times a week or as tolerated, ordered on 8/30/22. b. RNA to apply bilateral (both sides) knee brace (an external device to support, align, or correct a movable part of the body) for four (4) hours daily with skin check 5 times a week or as tolerated, ordered on 8/30/22. c. RNA to assist with PROM BUE once a day 5 times a week as tolerated, ordered on 9/13/22. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. RNA to assist with donning (put on) and doffing (take off) right elbow extension (to help straighten the elbow) splint (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) once a day six (6) hours a day 5 times a week as tolerated with skin check, ordered on 9/13/22. A review of Resident 120's MDS, dated [DATE], indicated the resident was not able to express ideas and wants and was not able to understand others. The MDS indicated Resident 120 required total dependence on staff for bed mobility, transfers (moving from one surface to another), dressing, toileting, and bathing. The MDS indicated Resident 120 had no functional range of motion impairments in either side of the upper or lower extremities. A review of Resident 120's History and Physical Examination dated 9/13/22 indicated the resident had upper extremity (UE, shoulder, elbow, wrist, hand) contractures and did not have the capacity to understand and make decisions. A review of Resident 120's September 2022 RNA Record indicated in the seven (7) days of the MDS assessment period (9/3/22 to 9/9/22), Resident 120 received 4 days of RNA for PROM exercises to BUE and BLE for at least 15 minutes and Resident 120 received 4 days of splinting and brace assistance. A review of Resident 120's MDS dated [DATE] indicated the resident required total dependence on staff for bed mobility, transfers, dressing, toileting, and bathing. The MDS indicated Resident 120 had functional range of motion impairments in both sides of the upper and lower extremities. The MDS indicated Resident 120 had zero days of restorative nursing program for PROM and 5 days of splint or brace assistance. A review of Resident 120's December 2022 RNA Record indicated in the seven days of the MDS assessment period (12/2/22 to 12/8/22), Resident 120 received 4 days of Restorative Nursing Program for PROM exercises to both BUE and BLE for at least 15 minutes and Resident 120 received 4 days of splinting and brace assistance. During an observation on 3/13/23 at 9:44 AM in Resident 120's room, Resident 120 was lying in bed with eyes opened and unable to speak. Resident 120 did not respond to any verbal cues. Resident 120 had both elbows bent and both hands were in a fisted position. On 3/16/23 at 11: 46 AM, during a concurrent interview and record review of Resident 120's MDS assessments, dated 9/9/22 and 12/8/22 and September 2022 and December 2022 RNA Records, the Minimum Data Set Nurse Coordinator 1 (MDS Nurse 1) stated during the 7-day assessment period for the MDS dated [DATE], Resident 120's functional range of motion limitations for both sides of the upper or lower extremities was coded as zero, which meant Resident 120 did not have any functional ROM limitation. The MDS assessment also indicated Resident 120 received zero days of Restorative Nursing Programs for passive range of motion and splinting/brace assistance. MDS Nurse 1 stated the assessment and coding was incorrect. MDS Nurse 1 stated Resident 120's functional limitation in range of motion impairment for both sides of the upper and lower extremities should have been coded as two (2) because the resident could not move and had contractures in both upper and lower extremities. Furthermore, MDS Nurse 1 stated that Resident 120 received 4 days of RNA for PROM and for splinting and brace assistance during the 7-day assessment period and should have been assessed as receiving 4 days of PROM and 4 days of splinting/brace assistance to accurately reflect the services the resident received at the facility. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In the same interview and record review, MDS Nurse 1 stated that during the 7-day assessment period for the MDS dated [DATE], Resident 120 was assessed as receiving zero days of RNA for PROM and 5 days of splinting/brace assistance. MDS Nurse 1 stated that a review of the December 2022 RNA Record indicated that Resident 120 received 4 days of RNA PROM exercises and 4 days of splinting/brace assistance. MDS Nurse 1 stated the MDS dated [DATE] was inaccurately assessed and should have been assessed as Resident 120 receiving 4 days of RNA for PROM and 4 days for splinting/brace assistance to accurately reflect the services the resident received at the facility. 2. A review of Resident 22's Admission Record indicated the resident initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including respiratory failure with hypoxia (low oxygen level in tissues) and contracture of muscle multiple sites. A review of Resident 22's History and Physical Examination dated 10/31/22 indicated Resident 22 had contractures, was receiving RNA services, and did not have the capacity to understand and make decisions. A review of Resident 22's physician's order summary report indicated the following: a. RNA to provide PROM exercises to BLE 5 times a week or as tolerated, ordered on 10/24/22. b. RNA to assist with PROM exercises to BUE five times a week as tolerated, ordered on 2/1/23. c. RNA to assist with donning/doffing both resting hand splints once a day for 3 to 4 hours a day, 5 times a week as tolerated with skin check, ordered on 2/1/23. A review of Resident 22's MDS dated [DATE] indicated the resident was not able to express wants and idea and was not able to understand others. The MDS indicated Resident 22 required total dependence on staff for bed mobility, dressing, toileting, and bathing. The MDS indicated Resident 22 had functional range of motion impairments in both sides of the upper and lower extremities. The MDS indicated Resident 22 received zero days of Restorative Nursing Programs for passive range of motion and zero days of splint or brace assistance. A review of Resident 22's January 2023 RNA Record indicated in the 7 days of the MDS assessment period (1/20/23 - 1/26/23), Resident 22 received 4 days of RNA for PROM exercises to both BUE and BLE for at least 15 minutes. During an observation on 3/14/23 at 2:09 PM in Resident 22's room, Resident 22 was lying in bed with eyes opened but did not respond to verbal cues. Resident 22's left arm was relaxed to the side, the left wrist was bent and rotated away from the body and the left fingers and hand was flexed. Resident 22's right arm was straight and resting to the side, the right wrist was bent and rotated away from the body and the fingers were bent. During an observation on 3/15/23 at 9:26 AM in Resident 22's room, Resident 22 was lying in bed. Resident 22's right leg was straight, the right ankle was plantar flexed (ankle bent and toes facing away from the body) and rotated towards the body. Resident 22's left leg was straight, the left ankle was plantar flexed and rotated towards the body. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/16/23 at 12:00 PM, during a concurrent interview and record review of Resident 22's MDS dated [DATE] and January 2023 RNA Record, the MDS Nurse 1 stated Resident 22 received 5 days of RNA exercises for PROM during the 7-day assessment period for MDS dated [DATE]. MDS Nurse 1 stated the MDS dated [DATE] indicated Resident 22 as receiving zero days of RNA for PROM, but this was not correct. MDS Nurse 1 stated the MDS should have been coded as 5 days of RNA for PROM motion to accurately reflect the services the resident received at the facility. 3. A review of Resident 106's Admission Record indicated the resident initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including congestive heart failure (weakness of the heart that leads to buildup of fluid in the lungs and other parts of the body), diabetes mellitus (a chronic disease that affects how the body processes sugar) with diabetic poly neuropathy (nerve damage caused by diabetes), and morbid obesity (disorder involving excessive body fat that increased risk for health problems). A review of Resident 106's physician's order summary report indicated the following: a. RNA to apply left hand carrot (device shaped like a carrot to help keep the fingers open) for four to six hours once a day, five times a week or as tolerated, ordered on 11/23/22. b. RNA to provide PROM to LUE once a day five times a week or as tolerated, ordered on 11/23/22. c. RNA to provide PROM exercises to BLE five times a week or as tolerated, ordered on 12/27/22. A review of Resident 106's MDS dated [DATE] indicated Resident 106 was cognitively intact. The MDS indicated Resident 106 required extensive assistance from staff for bed mobility, dressing, hygiene and total dependence on staff for bathing and toileting. The MDS indicated Resident 106 had no impairments in functional range of motion in both upper extremities and had impairments in functional range of motion in both lower extremities. The MDS indicated Resident 106 received zero days of restorative nursing programs. A review of Resident 106's January 2023 RNA Record indicated in the 7 days of the MDS assessment period (1/24/23 - 1/30/23) Resident 106 received 5 days of RNA for PROM exercises to both BUE and BLE for at least 15 minutes and 5 days of splinting assistance. On 3/13/23 at 9:25 AM, during an observation and interview with Resident 106 in the resident's room, Resident 106 was lying in bed. Resident 106 was able to move his right arm up and down without any limitations, the left middle to pinky fingers were flexed in a fist and the resident could not straighten the fingers. Resident 106 was able to move his left arm and both legs a little bit on his own, but not fully. Resident 106 had a blue carrot orthotic device in his left hand and stated that staff had to assist him with left arm and finger exercises and put a carrot in the left hand because his left hand did not work anymore. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/16/23 at 12:07 PM, during an interview and record review of Resident 106's MDS dated [DATE] and January 2023 RNA Record, MDS Nurse 1 stated the MDS assessment dated [DATE] indicated Resident 106 was assessed as no impairment for functional range of motion limitation of the upper extremities. MDS Nurse 1 stated it was not assessed correctly because Resident 106 had a functional range of motion limitation in the left hand and could not use it for functional activities. MDS Nurse 1 stated the MDS dated [DATE] should have been coded as one for functional range of motion impairment of one side of the upper extremity. MDS Nurse 1 also stated that the MDS dated [DATE] indicated Resident 106 received zero days of RNA for PROM and zero days of splint/brace assistance. MDS Nurse 1 stated the MDS was incorrect and should be coded as 5 days of PROM and 5 days of splinting assistance to accurately reflect the services Resident 106 received at the facility. 4. A review of Resident 81's Admission Record indicated the resident initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including respiratory failure, contracture of the right and left ankle, right and left hand, right and left elbow. A review of Resident 81's physician's order summary report indicated the following: a. RNA to perform PROM exercises to BUE once a day, five times a week or as tolerated, ordered on 9/9/21. b. RNA to apply both hand carrots for six hours once a day, five times a week or as tolerated, ordered on 9/14/21. c. RNA to provide PROM exercises to BLE five times a week or as tolerated, ordered on 1/12/22. A review of Resident 81's MDS dated [DATE] indicated the resident was not able to express wants and idea and was not able to understand others. The MDS indicated Resident 81 required total dependence on staff for bed mobility, dressing, toileting, and bathing. The MDS indicated Resident 81 had functional range of motion impairments in both sides of the upper and lower extremities. The MDS indicated Resident 81 received zero days of Restorative Nursing Programs for PROM and zero days of splint or brace assistance. A review of Resident 81's February 2023 RNA Record indicated in the 7-day MDS assessment period (2/16/23 - 2/21/23) Resident 81 received 5 days of RNA for PROM exercises to both BUE and BLE for at least 15 minutes and 5 days of splinting assistance. During an observation of Resident 81 on 3/14/23 at 2:21 PM in the resident's room, Resident 81 was lying in bed and had blue carrot splinting devices in both hands and the fingers were flexed around the carrots. Resident 81's left elbow was bent about halfway, and the right elbow was bent more than halfway. The left wrist was straight, and the right wrist was bent about halfway. On 3/16/23 at 2:59 PM, during a concurrent interview and record review of Resident 81's MDS dated [DATE] and February 2023 RNA Record, the MDS Nurse 1 stated the MDS dated [DATE] indicated Resident 81 did not receive any days of Restorative Nursing Programs. MDS Nurse 1 stated that during the 7-day MDS assessment period, February 2023 RNA Record indicated Resident 81 received 5 days of RNA for PROM and 5 days of splinting assistance. MDS Nurse 1 stated the MDS dated [DATE] was not accurately coded and stated the MDS should have coded as 5 days of RNA for PROM and 5 days for splinting assistance to accurately reflect the services Resident 81 received at the facility. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In the same interview, the MDS Nurse 1 stated the purpose of MDS assessments was to look at the quality of care provided to each resident and provided a picture of the resident and the services and treatments each resident was receiving at the facility. MDS Nurse 1 stated it was important that all MDS assessments be accurate because the facility used it to see the resident's present condition and what the resident needed. A review of the facility's policy and procedures, revised 3/22, titled, Comprehensive Assessments, indicated, comprehensive assessments are conducted in accordance with criteria and timeframes established in the Resident Assessment Instrument (RAI) User Manual (primary source of information for completing an MDS assessment). A significant error is an error in an assessment where the resident's overall clinical status is not accurately represented (i.e. miscoded) on the erroneous assessment.

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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** 40773 Based on observation, interview and record review, the facility failed to initiate a comprehensive care plan based on 7 Resident sampled Resident (Resident 32, 135, 10, 32, 54, 73, 108 and 482) by failing to: 1.Develop a care plan for the use of bed rails (also known as side rails [structural support attached to the frame of a bed and intended to prevent a patient from falling]) for Resident 32. 2.Develop a care plan for the use of bed rails (also known as side rails [structural support attached to the frame of a bed and intended to prevent a patient from falling]) for Resident 135. 3. Failure to develop care plan for Resident 73's use of Seroquel (is a medication used to treat certain mental/mood conditions (such as schizophrenia, bipolar disorder, sudden episodes of mania) with measurable goals for behavior of inconsolable screaming. 4. Failure to implement Resident 482's Fall care plan for bed in low position, floor mat/pad (a piece of cushion used to help minimize impact of fall on the floor) in place. 5. Develop a care plan for the use of bed rails (also known as side rails [structural support attached to the frame of a bed and intended to prevent a patient from falling]) for Resident 32 and Resident 135. 6. Develop a care plan for Residents 10, 54 and 108 with goals and interventions to address personal needs of an end-of-life patient (pain, shortness of breath, changes in appetite, spiritual and psychosocial needs related to dying). This deficient practice had the potential for residents' inability to meet his or her preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs. Findings: 1. A review of Resident 32's Admission Record indicated an initial admission to the facility on [DATE], and readmission on 1/25/17 with diagnoses of respiratory failure, tracheostomy (an opening created at the front of the neck so a tube can be inserted into the windpipe (trachea) to help you breathe), and ventilator dependence. A review of Resident 32's History and Physical dated 6/4/21 indicated Resident 32 did not have the capacity to understand or make decisions. A review of Resident 32's Minimum Data Set (MDS: a standardized assessment and care planning screening tool) dated 1/5/23, indicated Resident 32 was totally dependent (staff provide full support) with bed mobility, dressing, eating, toilet use, and personal hygiene. (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 observation in Resident 32's room on 3/13/23 at 10:36 AM, Resident 32 was observed in bed, with the head of bed up and pointing at the bedside television, using her right index finger. Resident 32 was nonverbal and was observed with bilateral upper bed rails utilized. 2. A review of Resident 135's Admission Record indicated an initial admission to the facility on [DATE], and readmission on 1/19/23 with diagnoses of paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease), urinary tract infection (an infection in any part of the urinary system), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). A review of Resident 135's MDS dated [DATE] indicated Resident 135 had no cognitive impairment. The MDS indicated Resident 138 required extensive assistance (staff provide weight bearing support) with one person assist with bed mobility, toilet use, and personal hygiene. The MDS indicated Resident 135 was totally dependent (full staff support) with dressing. Resident 135 required supervision with eating. During an observation In Resident 135's room on 3/13/23 at 11:06 AM, Resident 135 was observed in bed with bilateral side rails up and personal belongings on each side of her bed. Resident 135 had the bed side table pulled over her bed and was watching on her tablet. During a concurrent interview and record review of Resident 32's Care Plans on 3/15/23 at 3:02 PM, the Director of Nurses (DON) stated bed rails must have a care plan since it was a coordination of the plan of care, and a way of communicating care of the resident to other nurses. The DON stated interventions on care plans must be followed to ensure appropriate care for the residents with bed rails. The DON stated when a care plan was not initiated for the use of bed rails, staff may not know to assess and reassess the risk and safety for the use of bed rails. The DON stated risk for entrapment (when a person is trapped by the bed rail in a position they cannot move from) was possible with bed rail usage, therefore must be care planned. The DON acknowledged there were no care plans for bed rail usage for Resident 32. During a concurrent interview and record review of Resident 135's Care Plans on 3/16/23 at 10:05 AM, the Assistant Director of Nurses (ADON) stated licensed nurses (LN) were responsible in completing resident care plans. The ADON stated a care plan was the residents plan of care which was used as a guidance on how to care for the residents and should be reflective of their current status and condition. The ADON acknowledged no care plan initiated for bed rails for Resident 135. The ADON stated the care plan should have been completed to reflect the current care for Resident 135 since bed rails could pose risk factors, such as entrapment, for a resident. 42878 3. A review of Resident 73's Admission Record indicated resident was originally admitted to the facility on [DATE] and then readmitted on [DATE] with diagnosis that included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily functioning), generalized anxiety disorder(mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), Schizophrenia (affects a person's ability to think, feel, and behave clearly). (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 73's History and Physical (H&P) dated 7/02/22 indicated Resident 73 has the capacity to understand and make decisions. A review of the Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 2/07/2023, indicated Resident 73 required supervision (oversight, encouragement, cueing) for bed mobility, eating. The MDS indicated Resident 73 required one person limited assistance (resident highly involved in activity, staff provide guided maneuvering of limbs or other non-weight bearing assistance) transfer, walk in room, toilet use and personal hygiene. A review of Resident 73's Physician's order summary?? for the month of March 23, the physician ordered Seroquel tablet 50 milligrams (mg - a unit of measure for mass) give 1 tablet by mouth at bedtime for Schizophrenia manifested by inconsolable screaming A review of Resident 73's care plan dated 3/01/23 for exhibits or has the potential to demonstrate verbal behaviors related to psychiatric disorder: inconsolable screaming for Seroquel (Quetiapine furmate). The care plan did not indicate measurable goals or outcome for the inconsolable screaming. During an interview and concurrent record review on 3/16/23 at 8:13 PM with Assistant Director of Nurses (ADON), ADON stated Resident 73's care plan did not identify specific measurable outcomes for the use of Seroquel (Quetiapine furmate) manifested by inconsolable screaming. ADON stated it is important for Resident 73's care plan to include measurable outcomes for behaviors in order to know if the medication prescribed is effective in treating specific behaviors. 4. A review of Resident 482's Admission Record indicated resident was originally admitted to the facility on [DATE] and then readmitted on [DATE] with diagnosis that included, metabolic encephalopathy (a condition in which brain function is disturbed either temporarily or permanently),type 1 diabetes mellitus (a chronic condition in which the pancreas produces little or no insulin with diabetic polyneuropathy[a condition in which a person's peripheral nerves are damaged]) major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily functioning). A review of Resident 482's History and Physical (H&P) dated 3/09/23 indicated Resident 482 has fluctuating capacity to understand and make decisions. A review of the Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 3/01/2023, indicated Resident 482 required two- person assist and total dependence (full staff performance every time) for bed mobility. The MDS indicated Resident 482 requires one-person assist with total dependance for dressing, toilet use, personal hygiene. A review of Resident 482's Interdisciplinary fall care plan dated 03/07/23, indicated Resident 482's safety devices in place should include low bed, floor mat/pad. A review of Resident 482's fall care plan dated 10/17/22 with a revision date on 3/07/23, indicated Resident 482 will have less injury related to fall for 90 days. The care plan did not indicated floor mats/ pads under interventions. (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 observation and concurrent interview on with Licensed Vocational Nurse (LVN) 4 on 3/15/23 at 4:02 PM, Resident 482 was observed laying in bed leaning towards right side edge of bed, there were no floor mat or fall risk wrist band observed. Bed was observed in an elevated high position. LVN 4 stated Resident 482 was a high fall risk and should have fall precautions in place such as low bed, fall mats and a wrist band indicating he was a fall risk due to his history of falls and confusion. During an interview and concurrent record review on 3/15/23 with Director of Nurses (DON), DON stated Resident 482 is a high fall risk and the resident's care plan for fall should include floor mats/ pads to ensure facility staff implements the intervention to prevent fall. 42334 5. A review of Resident 10's Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on ,d+[DATE] with diagnoses of, but not limited to, end stage renal disease (the final stage of kidney failure), type 2 diabetes (a chronic disease that affects how the body processes sugar in the blood), heart failure (a chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs), and Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors.) A review of Resident 10's comprehensive admission Minimum Data Set (MDS - a standardized assessment and screening tool) dated 2/1/23 indicated the resident had impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making with difficulties in memory and making needs known. The MDS indicated the resident was extensively dependent to totally dependent on staff for activities of daily living (ADLs - term used in healthcare to refer to daily self-care activities). A review of Resident 10's physician's orders dated 1/24/23 indicated, the resident was admitted to hospice care services (a set of care and services specialized in the needs for the dying resident) on 1/24/23 with a primary diagnosis of End Stage Congestive Heart Failure (CHF, a condition in which the heart no longer pumps enough blood for the body). A review of Resident 10's care plan dated 1/26/23 indicated that the resident's goal for being on hospice was that hospice will provide support for coping grief/loss. The care plan indicated an intervention to reach this goal (initiated on 1/26/22, 2 months prior to) was to provide/facilitate spiritual support as desired/defined by client and family to address end of life wishes and other identified items. The care plan did not indicate what Resident 10's wishes, and other identified items were. During concurrent record review of Resident 10's medical records dated from 1/26/23 to 3/15/23 and interview with the Social Services Designee (SSD) on 3/16/2023 at 7:57 AM, the SSD stated, the facility's care plan for Resident 10's end of life wishes and other identified items did not include or specify the resident's end of life wishes, and other identified items. 6. A review of Resident 54's Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of, but not limited to, type 2 diabetes (heart failure, and anxiety (when feelings of worry become excessive, all-consuming, and interfere with daily living.) (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 54's comprehensive admission MDS dated [DATE], indicated the resident had impaired cognitive skills for daily decision-making with difficulties in memory and making needs known. The MDS indicated the resident was extensively dependent to totally dependent on staff for ADLs. A review of Resident 54's physician's orders dated 5/19/22 indicated the resident was admitted to hospice care services on 5/19/22 with a primary diagnosis of heart failure. A review of Resident 54's care plan revised on 11/2/22 indicated, the resident's goal (last revised 11/2/22 was resident will remain comfortable throughout the end-of-life journey. The plan of care indicated an intervention (no recent revisions) for that included to provide resident spiritual support as desired/defined by client and to address end of life wishes and other identified items. The care plan did not include what the life wishes, and other identified concerns of Resident 54 were. During concurrent record review of Resident 54's medical records dated from 5/19/222 to 3/15/23 and interview with the SSD on 3/16/23 at 8:15 AM, the SSD stated, that the facility's care plan for Resident 54's end of life wishes, and other identified items did not include or specify the resident's end of life wishes, and what were the other identified items. A review of Resident 108's Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of, but not limited to, dementia, (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change), body mass index (BMI- a value derived from the mass and height of a person) less than 19.99 (an individual would be considered to be underweight if his/her BMI was in the range of 15 to 19.9), and atherosclerosis of aorta (the buildup of fats, cholesterol and other substances in and on the artery walls). A review of Resident 108's comprehensive admission MDS dated [DATE], indicated the resident had impaired cognitive skills for daily decision-making with difficulties in memory and making needs known. The MDS indicated the resident was extensively dependent to totally dependent on staff for ADLs. A review of Resident 108's physician's orders dated 8/11/22 indicated the resident was admitted to hospice care services (a set of care and services specialized in the needs for the dying resident) on 8/11/22 with a primary diagnosis of Alzheimer's disease (type of dementia that affects memory, thinking and behavior). A review of Resident 108's care plan dated 5/18/22 with revision on 10/28/22 indicated, the resident's stated the goal was that the resident will be comfortable through the end-of-life journey. The care plan indicated the interventions to achieve this goal were to, provide emotional and social support to patient and to address end of life wishes/planning and other identified items but the care plan did not indicated what the resident desired in her care, or what the identified items were. During concurrent record review of Resident 108's medical records dated from 8/11/22 to 3/15/23 and interview with the SSD on 3/16/23at 8:30 AM, the SSD stated the facility's care plan for Resident 108's end of life wishes did not indicated or specify the resident's end of life wishes, and other identified items. During an interview with the Director of Nursing (DON) on 3/15/23 at 12:30 PM the DON stated that Resident 10 54, and 108's care plans should reflect the individual needs of the resident. (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 the facility's policy titled, Care Plan Comprehensive, dated 8/25/21, indicated, each resident's comprehension care plan is designed to build on the individual's needs, and reflect the resident's expressed wishes regarding care and treatment goals.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41379 Based on observation, interview, and record review, the facility failed to provide two of 10 sampled residents (Residents 160 and 106) with care and services to maintain the ability to perform activities of daily living (ADLs, basic daily activities such as eating, transferring, communicating) by failing to: 1. Assist Resident 160 out of bed daily or as requested by the resident. 2. Assist Resident 106 out of bed daily or as requested by the resident. These deficient practices had the potential for Residents 160 and 106 to experience a decline in overall physical and mental functioning, which can affect the residents' quality of life. Findings: 1. A review of Resident 160's Admission Record indicated the resident initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including but not limited to sepsis (presence in tissues of harmful bacteria and their toxins, typically through infection of a wound), metabolic encephalopathy (any damage or disease that affects the brain). A review of Resident 160's History and Physical dated 2/10/23 indicated the resident was in bed, did not walk, and did not have the capacity to understand and make decisions. A review of Resident 160's Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated 1/10/23 indicated the resident had severe cognitive impairment (difficulty with or unable to make decisions, learn, remembering things). The MDS indicated the resident sometimes had the ability to express ideas and wants and sometimes understood others. The MDS indicated the activity of transfer (moving from one surface to another such as bed to wheelchair) did not occur. The MDS indicated the resident required total dependence on staff for bed mobility, dressing, toileting, and bathing. The MDS indicted that no wheelchair mobility device was used. A review of the physician's order summary report indicated an order dated 1/4/23, may participate in activity and general conditioning program as desired. A review of Resident 160's care plan revised 1/6/23 indicated the resident required dependent assist for ADL care in bed mobility, transfers related to limited mobility. The care plan goal indicated that Resident 160's ADL care need would be anticipated and met. A review of Resident 160's ADL task report for January 2023 indicated the task of transfer did not occur or was blank on 1/1/23 to 1/8/23, 1/10/23 to 1/12/23, 1/15/23, 1/17/23, 1/18/23, and from 1/20/23 to 1/31/23. The ADL task report indicated Resident 160 was assisted with transferring out of bed five times in January 2023. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 160's ADL task report for February 2023 indicated the task of transfer did not occur or was blank on 2/2/23 to 2/10/23, 2/12/23 to 2/19/23, 2/21/23 to 2/28/23. It indicated Resident 160 was assisted with transferring out of bed four times in February 2023. A review of Resident 160's ADL task report for March 2023 indicated the task of transfer for the day and evening shifts, did not occur or was blank on 3/1/23 to 3/13/23. It indicated Resident 160 was assisted with transferring out of bed zero times thus far in March 2023. On 3/13/23 at 11:22 AM, during an observation in Resident 160's room, Resident 160 was lying in a bed of low height with eyes closed. Resident 160's roommate, Resident 79, stated Resident 160 was always in bed and did not get out of bed even if they requested staff to help Resident 160 out of bed. On 3/14/23 at 11:56 AM, during an observation and interview in Resident 160's room, Resident 160 was lying in a bed of low height with the head of bed upright about 30 degrees. Resident 160 was able to move the blankets with both arms to reveal her legs. Resident 160's knees were fully bent and the left heel was touching the left butt cheek. Resident 160's right heel was almost touching the right butt cheek. Resident 160 stated that she would like to get out of bed. Resident 160 stated she would like to get fresh air and go outside, but stated she was always in bed. There was no wheelchair or other durable medical equipment observed in the resident's room. On 3/15/23 at 8:38 AM, during an observation and interview with Resident 160 in the resident's room, Resident 160 was lying in a bed of low height with the head of bed upright about 45 degrees. Resident 160's hips and knees were fully flexed and rotated to the right side. Resident 160 was holding and using a cellular telephone with both hands. On 3/16/23 at 10:04 AM, during an observation in Resident 160's room, Resident 160 was lying in bed sleeping. During an interview on 3/16/23 at 10:07 AM, Registered Nurse 1 (RN 1) stated Resident 160 should get out of bed every day at least once during the day shift. RN 1 stated when staff did assist Resident 160 out of bed, RN 1 saw the resident laugh, smile, and was happy. RN 1 stated she was unsure how often Resident 160 got out of bed in a week. During an interview on 3/16/23 at 10:21 AM, Licensed Vocational Nurse 2 (LVN 2) stated Resident 160 was usually in bed and could verbalize her needs. LVN 2 stated during her shifts, Resident 160 usually did not get out of bed with staff. LVN 2 stated she observed the resident getting out of bed with staff only on shower days but would be put back to bed after the shower. 2. A review of Resident 106's Admission Record indicated the resident initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including congestive heart failure (weakness of the heart that leads to buildup of fluid in the lungs and other parts of the body), diabetes mellitus (a chronic disease that affects how the body processes sugar) with diabetic poly neuropathy (nerve damage caused by diabetes), and morbid obesity (disorder involving excessive body fat that increased risk for health problems). (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 106's Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated 1/30/23 indicated the resident was cognitively intact (sufficient judgement, planning, organization to manage average demands in one's environment). The MDS indicated the activity of transfer occurred only once or twice in the last seven days. The MDS indicated Resident 106 required extensive assistance (requires significant amount of assistance from another person to perform task) for bed mobility, dressing, personal hygiene and total dependence on staff for bathing and toileting. A review of Resident 106's care plan revised 3/14/23 indicated the resident required extensive to dependent assist for ADL care in bed mobility and transfers related to limited mobility. The care plan goal indicated for Resident 106's ADL care needs would be anticipated and met. A review of Resident 106's ADL task report for January 2023 indicated the task of transfer did not occur or was blank on 1/1/23, 1/5/23 to 1/8/23, 1/10/23, 1/14/23, 1/15/23, 1/17/23 to 1/24/23, 1/26/23 to 1/28/23, and from 1/29/23 to 1/31/23. It indicated Resident 106 was assisted with transferring out of bed 10 times in January 2023. A review of Resident 106's ADL task report for February 2023 indicated the task of transfer did not occur or was blank on 2/1/23 to 2/7/23, and from 2/9/23 to 2/28/23. It indicated Resident 106 was assisted with transferring out of bed one time in February 2023. A review of Resident 106's ADL task report for March 2023 indicated the task of transfer did not occur or was blank on 3/1/23 to 3/13/23. It indicated Resident 106 was assisted with transferring out of bed one time in March 2023. On 3/13/23 at 9:25 AM, during an observation and interview with Resident 106 in the resident's room, Resident 106 was lying in bed. Resident 106 stated that staff did not assist him out of bed even though he requested to get out of bed. Resident 106 was able to move his right arm up and down without any limitations, the left middle to pinky fingers were flexed in a fist and the resident could not straighten the fingers. Resident 106 was able to move his left arm and both legs a little bit on his own. Resident 106 stated he would like to get out of bed so he could attend activities in the activity room. On 3/14/23 at 11:39 AM, during an observation and interview with Resident 106 in the resident's room, Resident 106 was in bed and stated he had two wheelchairs and they were stored in the bathroom. Resident 106 stated staff did not get him out of bed into a wheelchair or into a shower chair for showers. Resident 106 stated he would like to get out of bed today. On 3/14/23 at 2:19 PM, during an observation and interview with Resident 106 in the resident's room, Resident 106 was sitting up in a wheelchair and smiling. Resident 106 stated, I'm up! Resident 106 stated that he had only been up about one to three percent of the time he had been living in the facility. During an interview on 3/16/23 at 9:45 AM, LVN 3 stated if a resident wanted to get out of bed, then the staff should assist the resident out of bed. LVN 3 stated Resident 106 probably got out of bed one to two times a week and required multiple staff to assist him out of bed. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/16/23 at 2:22 PM, the Director of Staff Development (DSD) stated that all residents should be getting of bed each day. DSD stated that if a resident requested to get out of bed, then staff should assist the resident out of bed. DSD stated the benefits of getting out of bed was continuing a routine for the resident, because residents would get out of bed every day when they were at home and now that the facility was their home, they should continue their normal routine. A review of the facility's policy and procedure reviewed 11/30/20, titled, Activities of Daily Living (ADL), indicated that based on .the patient's needs and choices, the Center must provide the necessary care and services to ensure that a patient's ADL abilities are maintained or improved and do not diminish .ADLs include: mobility - transfer and ambulation.

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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. 46779 Based on observation, interview, and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for one of forty sampled residents (Resident 159) by failure ensure transportation to a doctor's appointment and to reschedule the missed doctor's appointment. This deficient practice had the potential to negatively affected the resident's psychosocial well-being. Findings: A review of Resident 159's Admission Record indicated the facility admitted Resident 159, on 11/5/22, with diagnoses that included fracture (a break in bone) of wrist and hand and depression (a mental health problem that involves a low mood and a loss of interest in activities). A review of Resident 159's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 2/14/23, indicated Resident 159 had intact memory and cognition (ability to think and reason). Resident 159 required supervision (oversight, encouragement or cueing) with personal hygiene and limited assistance (resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance) with transfer, dressing, and toilet use. A review of Resident 159's History and Physical Examination (H&P), dated 11/5/22, indicated Resident 159 had the capacity to understand and make decisions. During a review of Resident 159's Order Summary, dated 2/22/23, indicated Resident 159 had an appointment scheduled with orthopedic (a branch of surgery concerned with conditions involving the musculoskeletal system) and hand specialist on 2/22/23 at 2 p.m. and 3/9/23 at 3:30 p.m. During an observation and interview, on 3/13/23 at 12:00 p.m., observed Resident 159 had a healed surgical scar on his right wrist. Resident 159 was able to move his right-hand fingers and bend his right wrist with a limited range, but he could not use his right hand to write or bear weight. Resident 159 stated he used to live alone at home, and it was very important for him to gain full function of his right hand, as a result, seeing the hand specialist as scheduled was very important to achieve his goal. Resident 159 stated he relied on the facility to schedule the doctor appointments, request for authorization, and arrangement for transportations to the doctor's appointments. Resident 159 stated he had a scheduled doctor appointment on 3/9/23 at 3:30 PM and he was getting dressed up and ready to go that day, then the staff asked where he was going. Resident 159 stated the staff later told him there was no transportation arranged for him to go to the doctor appointment on 3/9/23. Resident 159 stated it made him very angry because the facility was supposed to arrange the transportation and he trusted them to do so. Resident 159 further stated he was also very anxious because he was worried that he might lose the function of his right hand if he missed the doctor appointment and delaying his rehabilitate progress. Resident 159 stated the facility had not followed up with him or the doctor to reschedule his missed appointment yet, which made him even more anxious and helpless. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/14/23, at 9:30 a.m., Licensed Vocational Nurse (LVN) 7 stated when a resident returned from a doctor's appointment, the receiving nurse would check if the resident had a follow-up appointment and it was scheduled by asking the resident, a written order from the doctor inside the appointment envelope or calling the doctor's office. LVN 7 stated once the nurse confirmed there was a follow-up appointment, the nurse would put in as a phone order into the resident's chart on Point Click Care (PCC, a web-based electronic health record and practice management solution for long-term and post-acute care organizations). LVN 7 further stated the nurse print out the order and send it to social service to arrange transportation. LVN 7 stated once the transportation was arranged, social service would prepare an envelope with the resident's information and put it in the wall file folder designated for appointment that needed transportation in the nursing station. LVN 7 stated she was not aware of the missed appointment for Resident 159 on 3/9/23 and was not sure which staff was responsible to reschedule for the missed appointment. LVN 7 did not answer when asked what happened if the nurse forgot to physically hand the appointment order to the social service and social service did not arrange transportation because social service did not receive the appointment notice. During a concurrent interview and record review, on 3/14/23 at 10:00 a.m., Registered Nurse (RN) 4 stated he was not aware of Resident 159's missed doctor appointment on 3/9/23 until this morning and was trying to call the doctor's office to schedule a follow-up appointment for Resident 159 today. RN 4 stated on 2/22/23, an order for appointment with the hand specialist on 3/9/23 at 3:30 p.m. was entered in Resident 159's chart on PCC. RN 4 stated the nurse should have sent a notice to the social service physically after entering the order. RN 4 stated he did not see any documentation on the nurse sending an appointment notice to social service in the nursing progress notes and he did not know if the social service was notified of this appointment. During a concurrent interview, on 3/14/23, at 11:28 a.m., the Social Service Specialist (SSS) stated social service did not receive an appointment notice on 3/9/23 for Resident 159. SSS stated the nurse had to physically hand in an appointment notice to social service for transportation arrangement. SSS stated if social service did not have the notice in their record, thus, the social service would not know there was an appointment for Resident 159 and would not make a transportation arrangement for it. SSS stated the nurses were responsible to make a doctor's appointment or reschedule a missed appointment and social service was only responsible to arrange transportation if an appointment notice was received. During an interview, on 3/15/23 at 1:05 p.m., with RN 4, after confirming with SSS that social service did not receive the appointment notice for Resident 159 on 3/9/23, RN 4 stated the nurse who entered the appointment order on 2/22/23 probably forgot to send in the appointment notice to social service. RN 4 stated there was a break in the communication between the nurses and social service for the transportation arrangement. RN 4 stated there had not been a designated staff to oversee the transportations for doctor's appointments or rescheduling for missed doctor's appointments. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 3/15/23 at 2:03 p.m., the Director of Nursing (DON) stated the nurse would check if the resident had a follow-up doctor's appointment and put in the order into the resident's chart on PCC. DON stated the nurse would physically hand it to the social service to arrange transportation. DON stated when the transportation was arranged, social service would put the prepared envelope in a wall file folder designated for appointment that needed transportation in the nursing station. DON stated RN supervisor was responsible to rescheduling for a missed doctor's appointment as soon as possible. DON stated there was a gap in communication between the nurses and social services if the nurses forgot to send in the appointment notice to social services and the facility did not have a monitoring system to ensure the transportation arranged for each appointment and rescheduling the missed doctor's appointments. A review of the facility's policy and procedure titled, Transportation, Diagnostic Services, dated December 2008, indicated should it become necessary for the facility to provided transportation, the Social Service Designee will be responsible for arranging the transportation through the business office and Request for transportation should be made as far in advance as possible. A review of the facility's policy and procedure titled, Referrals, Social Services, dated December 2008, indicated social services will collaborate with nursing staff or other pertinent disciplines to arrange for services that have been ordered by the physician.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40773 Based on observation, interview and record review, the facility failed to provide the necessary care and services for two of four sampled residents (Residents 34 and 147) who were high risk for developing pressure injuries (areas of damaged skin caused by staying in one position for too long which reduces blood flow to the area and cause the skin to die and develop a sore) by failing to: 1. Ensure Resident 147 was free from developing moisture acquired skin damage (MASD: inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva, or mucus) on 3/14/23 to the Sacro coccyx area and had the potential for poor wound healing and other complications due to multiple comorbidity conditions which included diabetes mellitus. 2. Ensure Resident 34's alternating pressure mattress (provides pressure redistribution by filling and un-filling air cells within the mattress so that contact points with the body are reduced) was always kept on while resident is in bed. These deficient practices had the potential to cause further skin breakdown and delay of wound healing for Residents 34 and 147. Findings: 1. During an observation in Resident 147's room on 3/13/23 at 11:06 AM, Resident 147 was observed lying in bed on a regular mattress and a pillow in between her legs. Resident 147 was not able to move her legs, but able to move her arms. Resident 147 was uncovered and wearing a facility provided gown. A review of Resident 147's Admission Record indicated an initial admission to the facility on [DATE], and readmission on 1/4/23 with diagnoses of Lupus Erythematosus (an autoimmune disease in which the immune system attacks its own tissues, causing widespread inflammation and tissue damage in the affected organs), diabetes mellitus (elevated blood glucose levels), and legal blindness. A review of Resident 147's Minimum Data Set (MDS: a standardized assessment and care planning screening tool) dated 1/24/23 indicated Resident 147 had no cognitive impairment. The MDS indicated Resident 147 was totally dependent (staff provide full support) with one person assist for bed mobility, transfers, dressing, and personal hygiene. The MDS indicated Resident 147 was totally dependent with two-person assist with toilet use and required extensive assistance (staff provide weight bearing support) with eating. The MDS indicated Resident 147 was at risk for developing pressure injuries (injury to skin and underlying tissue resulting from prolonged pressure on the skin). A review of Resident 147's initial Braden Scale Assessment for Predicting Pressure Sore Risk on readmission, dated 1/4/23 and was assessed at mild risk in developing a pressure related injury. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 147's Activity of Daily Living (ADL) Record for 3/23, indicated no toilet use/care performed during the night shift (11 PM-7 AM) on 3/12/23, 3/13/23, 3/14/23, and 3/15/23. The ADL Record indicated no toilet use/care performed during the evening shift (3 PM-11 PM) on 3/12/23, 3/13/23, 3/14/23, and 3/15/23. A review of Resident 147's ADL Record for 03/2023, indicated no bladder care performed on 3/12/23, 2/13/23, 3/14/23, and 3/15/23 during the night and evening shift. A review of Resident 147's ADL Record for 03/2023 indicated no bowel care performed on 3/12/23, 3/13/23, 3/14/23, and 3/15/23 for night, day (7AM-3PM), and evening shift. A review of Resident 147's Care Plan for Sacro coccyx area MASD, indicated an initiation date of 3/14/23, with interventions included to keep resident clean and dry. During an interview on 3/13/23 at 11:17 AM, Resident 147 stated she was blind and was only able to see shadows. Resident 147 stated her brief had not been changed during the prior night shift (11 PM-7 AM). Resident 147 stated night shift never changes her diaper. During an interview on 3/14/23 at 9:19 AM, Resident 147 stated night shift did not change Resident 147's diaper and that her bottom was itchy. During an interview on 3/16/23 at 7:17 AM, certified nurse assistant (CNA 2) stated diaper changes for residents were done at least 2 to 3 times a shift, and as needed, depending on the resident. CNA 2 stated when a resident was in a wet diaper for too long, the moisture could damage and open the skin. CNA 2 stated diaper changes were documented on the ADL record flowsheet for the residents. During an interview on 3/16/23 at 7:36 AM, the Director of Staff Development (DSD) stated residents must be checked and repositioned every two hours if they are at risk for skin breakdown. The DSD stated toileting care was done to assist residents and to prevent skin breakdown, such as pressure ulcer and open wound. The DSD stated when residents are not changed timely and exposed to moisture from urine or feces in their diaper for a long period of time, MASD could develop. During an interview on 3/16/23 at 10:11AM, the Assistant Director of Nurses (ADON) stated MASD was a contributing factor from long exposure to moisture such as that in a brief (diaper) and would usually occur in the buttock and perineal area, or any skin folds. The ADON stated residents with fragile skin and who wore briefs were at higher risk in developing MASD. The ADON stated to avoid an MASD, the resident should be kept clean and dry and to change diapers 2 to 3 times or as needed depending on the resident's condition. The ADON stated Resident 147 was high risk in developing skin breakdown since Resident 147 was totally dependent on staff for ADLs The ADON stated Resident 147 was high risk since she was also a dialysis resident. 42878 2. A review of Resident 34's Face Sheet indicated Resident 34 was admitted to the facility on [DATE], with diagnoses including pressure ulcer of sacral region (located below the lumbar spine and above the tailbone), stage 3 (full thickness tissue loss) and type 2 diabetes mellitus (a disease in which your blood glucose, or blood sugar, levels are too high.) (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 34's Minimum Data Set (MDS, a standardized resident assessment and care planning tool) dated 2/19/23, indicated Resident 34's cognitive skills (the ways that your brain remembers, reasons, holds attention, solves problems, thinks, reads, and learns) were intact. The MDS indicated Resident 34 required extensive (resident involved in activity, staff provide guided maneuvering) one person assistance in bed mobility, personal hygiene. The MDS indicated Resident 34 was totally dependent (needing the support of something or someone in order to continue existing) to staff for transfer, dressing and toilet use. The MDS section titled Skin Conditions indicated Resident 34 Skin and Ulcer/Injury treatments should include pressure reducing device for bed. A review of Resident 34's care plan, initiated on 2/16/23, indicated Sacro coccyx (A triangular bone at the base of the spine pressure injury stage 3. The interventions included monitor for further breakdown, assist with repositioning to resident comfort, wound consult, and low air loss mattress. During an observation in Resident 34's room on 3/14/23 at 9:26 AM, Resident 34 was observed in bed in supine (lying facing upward) position, head of bed elevated with the air mattress deflated, display observed off and power cords disconnected from the power source and on the floor underneath Resident's 34 bed. During an observation in Resident's 34 room, and concurrent interview on 03/14/23 at 9:32 AM with Treatment Nurse 1 (TN1), the TN stated Resident 34 low air loss mattress should always be on and in the correct setting to help prevent worsening of existing pressure ulcer injury and or development of a new pressure injury. TN 1 stated she did not know why it was off as she was not notified. During an interview on 3/14/23 at 9:55 AM with Certified Nursing Assistant 4 (CNA 4) stated he was assigned to care for Resident 34 and did not notice the low air loss mattress was off. CNA 4 stated he worked for registry (a group of contracted nurses that work independently, contracted by the facility to come in temporarily) and was never in serviced or told from the facility anything regarding Low air loss mattress. During an interview on 3/16/23 at 07:36 AM, the Director of Staff Development (DSD) stated it is all CNAs including registry CNA's responsibility to make sure the low air loss mattress are always on when resident is on bed. The DSD stated, if they (CNAs) have any questions or concerns they will ask the treatment nurse. A review of the facility's Policy and Procedure titled, Activity of Daily Living, revised on 6/1/21, indicated a patient who is unable to carry out ADL's would receive the necessary level of ADL assistance to maintain good nutrition, grooming, and personal and oral hygiene. The policy indicated ADL's include Elimination-Toileting. The policy indicated ADL assistance that was not documented within 24 hours of occurring was considered late. The policy indicated the purpose was to ensure ADLs were provided in accordance with accepted standards of practice, the care plan, and the patient's choice and preference. A review of the facility's Policy and Procedure titled, Surface Support Guidelines, revised 09/13, indicated support surface alone are not effective in preventing pressure ulcers. The policy indicated elements of support surfaces that are critical to pressure ulcer prevention and general safety include pressure distribution and moisture control. The policy indicated any individual at risk for developing pressure ulcers should be placed on a redistribution support surface, such as a foam, gel, static air, alternating air, or air-loss or gel when lying in bed.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41379 Based on observation, interview, and record review, the facility failed to provide treatments and services to minimize the decline in mobility and joint range of motion (ROM, full movement potential of a joint) for four of 40 sampled residents (Residents 120, 22, 157, and 81) who had limited range of motion and functional mobility when the facility failed to ensure: 1. a. Resident 120 received Restorative Nursing Aide (RNA) program (nursing aide program to help residents maintain their function and joint mobility) treatments for passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises to both lower extremities (BLE, hip, knee, ankle, foot) and both upper extremities (BUE, shoulder, elbow, wrist, hand) five (5) times a week as ordered by a physician. In addition, ensure Resident 120 received RNA program to apply bilateral (both sides) knee brace (an external device to support, align, or correct a movable part of the body) for four (4) hours daily 5 times a week and for RNA to assist with donning (put on) and doffing (take off) right elbow extension (to help straighten the elbow) splint (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) daily for six (6) hours a day, 5 times a week as ordered by a physician. b. RNA applied both knee braces to Resident 120 not exceeding 4 hours a day, 5 times a week as ordered by a physician. 2. a. Resident 22 received RNA program treatments for PROM exercises to BUE and BLE 5 times a week as ordered by a physician. In addition, ensure Resident 22 received RNA to assist with donning/doffing both resting hand splints for three (3) to 4 hours a day, 5 times a week as ordered by a physician. b. RNA applied both resting hand splints to Resident 22 not exceeding 3 to 4 hours a day, 5 times a week as ordered by a physician. 3. a. Resident 157 received RNA treatments for PROM exercises to BUE and BLE daily 5 times a week as ordered by a physician. In addition, ensure Resident 157 received RNA to apply both ankle Theraboots (a type of splint for the foot/ankle) for 3 hours daily 5 times a week and for RNA to apply both resting hand splints for 4-6 hours daily 5 times a week as ordered by a physician. b. RNA applied both ankle Theraboots to Resident 157 not exceeding 3 hours a day 5 times a week as ordered by a physician. 4. Resident 81 received RNA program treatments for PROM exercises to BUE 5 times a week and for RNA to apply both hand carrots (orthotic device shaped like a carrot to help keep the fingers open) for 6 hours daily, 5 times a week as ordered by a physician. In addition, ensure Resident 81 received RNA to provide PROM exercises to BLE 5 times a week as ordered by a physician. These deficient practices had the potential to cause worsening of contractures (loss of motion of a joint), pain, and skin breakdown for Residents 120, 22, 157, and 81. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CROSS REFERENCE TO F725 Findings: 1. A review of Resident 120's Admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including acute and chronic respiratory failure (any condition that affects breathing function and result in lungs not functioning properly), contracture of muscle multiple sites, functional quadriplegia (weakness or paralysis to all four extremities). A review of Resident 120's History and Physical examination dated 9/13/22 indicated Resident 120 had upper extremity contractures and did not have the capacity to understand and make decisions. A review of Resident 120's Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated 12/8/22 indicated Resident 120 required total dependence on staff for bed mobility, transfers, dressing, toileting, and bathing. The MDS indicated Resident 120 had functional range of motion impairments in BUE and BLE. A review of the physician's order summary report indicated an order: a. On 8/30/22 for RNA to provide PROM exercises to BLE 5 times a week or as tolerated and for RNA to apply both knee brace for 4 hours daily with skin check 5 times a week or as tolerated. b. On 9/13/22 for RNA to assist with PROM BUE once a day 5 times a week as tolerated and for RNA to assist with donning and doffing right elbow extension (to help straighten the elbow) splint once a day 6 hours a day 5 times a week as tolerated with skin check. A review of Resident 120's care plan dated 8/30/22 indicated Resident 120 was at risk for decline in ROM in BLE. The care plan indicated Resident 120 will maintain current BLE ROM and prevent contracture from developing or getting worse in both knees. The care plan intervention indicated for RNA to apply both knee braces for 4 hours daily with skin check 5 times a week or as tolerated and to provide PROM to BLE 5 times a week or as tolerated. A review of Resident 120's care plan dated 9/13/22 indicated Resident 120 was at risk for decline in ROM in BUE. The care plan indicated Resident 120 will maintain the current ROM to BUE. The care plan indicated the interventions to include RNA for PROM to BUE once a day 5 times a week as tolerated, and for RNA to assist with donning and doffing right elbow extension splint once a day, 6 hours a day, 5 times a week as tolerated with skin check. During an observation on 3/13/23 at 9:44 AM in Resident 120's room, Resident 120 was lying in bed with eyes opened and unable to speak. Resident 120 did not respond to any verbal cues. Resident 120 had both elbows bent and both hands were in a fisted position. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1.a. A review of Resident 120's September 2022 RNA Record documentation for RNA treatment for PROM exercises to BLE 5 times a week as tolerated and RNA to apply both knee braces 5 times a week for 4 hours as tolerated did not indicate RNA initials and length of treatment session for the following days: 9/1/22, 9/2/22, 9/9/22, 9/14/22, 9/15/22, 9/16/22, 9/23/22, and 9/30/22. There was a total of eight (8) missed RNA treatments to provide PROM exercise to BLE and apply both knee braces in September 2022. A review of Resident 120's September 2022 RNA Record documentation for RNA treatment for PROM exercises to BUE 5 times a week as tolerated and RNA to apply right elbow splint 5 times a week for 6 hours as tolerated did not indicate RNA initials and length of treatment session for the following days: 9/14/22, 9/15/22, 9/16/22, 9/23/22, and 9/30/22. There was a total of 5 missed RNA treatments to provide PROM exercises to BUE and to apply right elbow splint in September 2022. A review of Resident 120's October 2022 to February 2023 RNA Record documentation for RNA treatment for PROM exercises to BLE 5 times a week as tolerated, and RNA to apply both knee braces 5 times a week for 4 hours as tolerated, RNA treatment for PROM exercises to BUE 5 times a week as tolerated, and RNA to apply right elbow splint 5 times a week for 6 hours as tolerated did not indicate RNA initials and length of treatment session for the following days: 1.a.1 On 10/7/22, 10/14/22, 10/21/22, and 10/28/22. There was a total of 4 missed RNA treatments in October 2022. 1.a.2 On 11/1/22, 11/2/22, 11/3/22, 11/4/22, 11/11/22, 11/18/22, 11/25/22, and 11/30/22. There was a total of 8 missed RNA treatments in November 2022. 1.a.3 On 12/1/22, 12/2/22, 12/9/22, 12/13/22, 12/14/22, 12/15/22, 12/16/22, 12/19/22, 12/23/22, and 12/30/22. There was a total of 10 missed RNA treatments in December 2022. 1.a.4 On 1/3/23, 1/4/23, 1/5/23, 1/6/23, 1/9/23, 1/10/23, 1/11/23, 1/12/23, 1/13/23, 1/16/23, and 1/17/23. There was a total of 11 missed RNA treatments in January 2023. 1.a.5 On 2/10/23 and 2/17/23. There was a total of 2 missed RNA treatments in February 2023. 1.b. A review of Resident 120's Physical Therapy Evaluation dated 8/30/22 indicated Resident 120 was at the same functional status and did not require skilled PT intervention at the time. The PT Evaluation indicated to refer Resident 120 back to an RNA program for PROM to BLE and to don/doff both knee braces for 4 hours. A review of Resident 120's September 2022 to March 2023 RNA Record documentation for RNA treatment for RNA to apply both knee braces 5 times a week for 4 hours as tolerated indicated the following: 1.b.1 For the month of September 2022, indicated RNA put on both knee braces for 6 hours (2 hours longer than physician's order) on the following days: 9/5/22, 9/6/22, 9/7/22, 9/8/22, 9/12/22, 9/19/22, 9/20/22, 9/21/22, 9/22/22, 9/26/22, 9/27/22, 9/28/22, and 9/29/22. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1.b.2 For the month of October 2022, indicated RNA put on both knee braces for 5 or 6 hours (1-2 hours longer than physician's order) on the following days: 10/3/22, 10/4/22, 10/5/22, 10/6/22, 10/10/22, 10/11/22, 10/12/22, 10/13/22, 10/17/22, 10/18/22, 10/19/22, 10/20/22, 10/24/22, 10/25/22, 10/26/22, 10/27/22, and 10/31/22. 1.b.3 For the month of November 2022, indicated RNA put on both knee braces for 6 hours (2 hours longer than physician's order) on the following days: 11/7/22, 11/8/22, 11/9/22, 11/10/22, 11/14/22, 11/15/22, 1/16/22, 11/17/22, 11/21/22, 11/22/22, 11/23/22, 11/24/22, 11/28/22, and 11/29/22. 1.b.4 For the month of December 2022, indicated RNA put on both knee braces for 5 or 6 hours (1-2 hours longer than physician's order) on the following days: 12/5/22, 12/7/22, 12/8/22, 12/12/22, 12/20/22, 12/21/22, 12/22/22, 12/26/22, 12/27/22, 12/28/22, and 12/29/22. 1.b.5 For the month of January 2023, indicated RNA put on both knee braces for 5 to 6 hours (1-2 hours longer than physician's order) on the following days: 1/2/23, 1/18/23, 1/19/23, 1/20/23, 1/23/23, 1/24/23, 1/25/23, 1/26/23, 1/27/23, 1/28/23, 1/29/23, 1/30/23, and 1/31/23. 1.b.6 For the month of February 2023, indicated RNA put on both knee braces for 5 to 6 hours (1-2 hours longer than physician's order) on the following days: 2/1/23, 2/2/23, 2/3/23, 2/7/23, 2/8/23, 2/13/23, 2/14/23, 2/15/23, 2/16/23, 2/19/23, 2/20/23, 2/21/23, 2/22/23, 2/23/23, 2/27/23, and 2/28/23. 1.b.7 For the month of March 2023, indicated RNA put on both knee braces for 5 to 6 hours (1-2 hours longer than physician's order) on the following days: 3/1/23, 3/2/23, 3/3/23, 3/6/23, 3/8/23, 3/9/23, 3/10/23, 3/13/23, and 3/14/23. 2. A review of Resident 22's Admission Record indicated the resident initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including respiratory failure with hypoxia (low oxygen level in tissues) and contracture of muscle multiple sites. A review of Resident 22's History and Physical Examination dated 10/31/22 indicated Resident 22 had contractures, was receiving RNA services, and did not have the capacity to understand and make decisions. A review of Resident 22's MDS dated [DATE] indicated Resident 22 was not able to express wants and idea and was not able to understand others. The MDS indicated Resident 22 required total dependence on staff for bed mobility, dressing, toileting, and bathing. The MDS indicated Resident 22 had functional range of motion impairments in both sides of the upper and lower extremities. A review of the physician's order summary report indicated an order dated 10/24/22 for RNA to provide PROM exercises to BLE 5 times a week or as tolerated. The physician's order summary report indicated an order dated 2/1/23 for RNA to assist with PROM exercises to BUE 5 times a week as tolerated and for RNA to assist with donning/doffing both resting hand splints once a day for 3 to 4 hours a day, 5 times a week as tolerated with skin check. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rio Hondo Subacute & Nursing Center	273 E Beverly Boulevard Montebello, CA 90640

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 22's care plan dated 10/24/22 indicated Resident 22 was at risk for decline in ROM in BLE. The care plan indicated Resident 22 will maintain current ROM in BLE and prevent contracture from developing and/or getting worse in both ankles. The care plan intervention indicated for RNA to provide PROM exercises to BLE 5 times a week or as tolerated. A review of Resident 22's care plan dated 2/1/23 indicated Resident 22 was at risk for decline in ROM to BUE. The care plan indicated Resident 22 will maintain current ROM to BUE. The care plan intervention indicated for RNA to assist with PROM to BUE 5 times a week as tolerated and for RNA to assist with donning and doffing of both resting hand splints 3-4 hours a day, 5 times a week as tolerated with skin check. During an observation on 3/14/23 at 2:09 PM in Resident 22's room, Resident 22 was lying in bed with eyes opened but did not respond to verbal cues. Resident 22's left arm was relaxed to the side, the left wrist was bent and rotated away from the body and the left fingers and hand was bent. Resident 22's right elbow was straight and resting to the side, the right wrist was bent and rotated away from the body and the fingers were bent. During an observation on 3/15/23 at 9:26 AM in Resident 22's room, Resident 22 was lying in bed. The resident's right leg was straight, the right ankle was bent and toes were pointed away from the body and rotated towards the body. Resident 22's left leg was straight, the left ankle was bent and toes were pointed away from the body and rotated towards the body. 2.a. A review of Resident 22's September 2022 to February 2023 RNA Record documentation for RNA treatment for PROM exercises to BUE 5 times a week as tolerated and RNA for PROM exercises to BLE 5 times a week as tolerated did not indicate RNA initials and length of treatment session for the following days: 2.a.1 On 9/1/22, 9/2/22, 9/9/22, 9/14/22, 9/15/22, 9/16/22, 9/23/22, and 9/30/22. There was a total of 8 missed RNA treatments in September 2022. 2.a.2 On 11/1/22, 11/2/22, 11/3/22, 11/4/22, 11/11/22, 11/18/22, 11/25/22, and 11/30/22. There was a total of 8 missed RNA treatments in November 2022. 2.a.3 On 12/1/22, 12/2/22, 12/9/22, 12/13/22, 12/14/22, 12/15/22, 12/16/22, 12/19/22, 12/23/22, and 12/30/22. There was a total of 10 missed RNA treatments in December 2022. 2.a.4 On 1/3/23, 1/4/23, 1/5/23, 1/6/23, 1/9/23, 1/10/23, 1/11/23, 1/12/23, 1/13/23, 1/16/23, and 1/17/23. There was a total of 11 missed RNA treatments in January 2023. 2.a.5 On 2/10/23 and 2/17/23. There was a total of 2 missed RNA treatments in February 2023. 2.b. A review of Resident 22's February 2023 and March 2023 RNA Record documentation for RNA treatment for RNA to apply both resting hand splints 5 times a week for 3-4 hours as tolerated indicated RNA put on both resting hand splints for 5 or 6 hours (1-2 hours longer than physician's order) on the following days: 2/6/23, 2/8/23, 2/13/23, 2/14/23, 2/15/23, 2/16/23, 2/19/23, 2/20/23, 2/21/23, 2/23/23, 2/28/23, 3/2/23, 3/6/23, 3/7/23, 3/9/23, 3/10/23, and 3/14/23. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. A review of Resident 157's Admission Record indicated the resident admitted to the facility on [DATE] with diagnoses including acute respiratory failure (any condition that affects breathing function and result in lungs not functioning properly) with hypoxia and quadriplegia. A review of Resident 157's MDS dated [DATE] indicated Resident 157 required total dependence on staff for bed mobility, eating, dressing, toileting, and bathing. The MDS indicated Resident 157 had functional range of motion impairments in both sides of the upper and lower extremities. A review of Resident 157's physician's order summary report indicated an order dated 2/23/23 for RNA to apply both ankle Theraboots with skin check for 3 hours daily 5 times a week or as tolerated. The physician's order summary report indicated an order dated 2/23/23 for RNA to apply both resting hand splints for 4-6 hours once daily, 5 times a week or as tolerated with skin check. The physician's order summary report indicated an order dated 2/23/23 for RNA to provide PROM exercises to BLE 5 times a week or as tolerated. The physician's order summary report indicated an order dated 2/23/23 for RNA to provide PROM to BUE once daily, 5 times a week or as tolerated. A review of Resident 157's care plan dated 2/23/23 indicated Resident 157 was at risk of contractures to BUE. The care plan indicated Resident 157 will maintain current BUE ROM. The care plan indicated the intervention for RNA to apply both resting hand splints for 4-6 hours daily, 5 times a week or as tolerated with skin check and for RNA to provide PROM to BUE once daily, 5 times a week or as tolerated. A review of Resident 157's care plan dated 2/23/23 indicated Resident 157 was at risk for decline in BLE ROM. The care plan indicated Resident 157 will maintain the current BLE ROM and prevent contracture from developing and/or getting worse in both ankle plantar flexion (ankle bent with toes pointing away from the body). The care plan indicated the interventions to include RNA to provide PROM exercises to BLE and to apply both ankle Theraboots with skin check for 3 hours daily, 5 times a week or as tolerated. During an observation on 3/15/23 at 8:49 AM in Resident 157's room, Resident 157 was lying in bed with the eyes closed. Resident 157's left arm was bent about more than halfway, the right elbow was bent almost all the way and both knees appeared slightly bent. 3.a. A review of Resident 157's November 2022 to January 2023 RNA Record documentation for RNA treatment for PROM exercises to BLE 5 times a week as tolerated did not indicate RNA initials and length of treatment session for the following days: 3.a.1 On 11/1/22, 11/2/22, 11/3/22, 11/4/22, 11/11/22, 11/18/22, 11/25/22, and 11/30/22. There was a total of 8 missed RNA treatments in November 2022. 3.a.2 On 12/1/22, 12/2/22, 12/9/22, 12/13/22, 12/14/22, 12/15/22, 12/16/22, 12/19/22, 12/21/22, 12/22/22, 12/23/22, 12/26/22, 12/27/22, 12/28/22, 12/29/22, 12/30/22. There was a total of 16 missed RNA treatments in December 2022. 3.a.3 On 1/3/23, 1/4/23, 1/5/23, 1/6/23, 1/9/23, 1/10/23, 1/11/23, 1/12/23, 1/13/23, 1/16/23, 1/17/23. There was a total of 11 missed RNA treatments in January 2023. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 81's September 2022 to February 2023 RNA Record documentation for RNA treatment for PROM exercises to BLE 5 times a week as tolerated, RNA to perform PROM exercises to BUE 5 times a week as tolerated, RNA to apply both hand carrots 5 times a week for 6 hours or as tolerated did not indicate RNA initials and length of treatment session for the following days: a. On 9/1/22, 9/2/22, 9/9/22, 9/14/22, 9/15/22, 9/16/22, 9/23/22, and 9/30/22. There was a total of 8 missed RNA treatments in September 2022. b. On 10/7/22, 10/14/22, and 10/28/22. There was a total of 3 missed RNA treatments in October 2022. c. On 11/1/22, 11/2/22, 11/3/22, 11/4/22, 11/11/22, 11/18/22, 11/25/22, and 11/30/22. There was a total of 8 missed RNA treatments in November 2022. d. On 12/1/22, 12/2/22, 12/9/22, 12/13/22, 12/14/22, 12/15/22, 12/16/22, 12/19/22, 12/23/22, and 12/30/22. There was a total of 10 missed RNA treatments in December 2022. e. On 1/3/23, 1/4/23, 1/5/23, 1/6/23, 1/9/23, 1/10/23, 1/11/23, 1/12/23, 1/13/23, 1/16/23, and 1/17/23. There was a total of 11 missed RNA treatments in January 2023. f. On 2/10/23 and 2/17/23. There was a total of 2 missed RNA treatments in February 2023. During an interview on 3/15/23 at 10:13 AM, the Restorative Nursing Aide 2 (RNA 2) stated in the RNA Record, an initial meant the RNA completed the treatment that day and the number was the minutes it took to complete the RNA session. RNA 2 stated the number for splints or braces meant the numbers of hours the resident wore the splint or brace that day. RNA 2 reviewed the RNA Record for Residents 22 and 157 and confirmed that RNAs were applying splints and braces for longer than the time indicated on the RNA order. RNA 2 stated that because the order indicated, as tolerated, the RNAs could put on the splints and braces for longer than the duration on the order. RNA 2 stated that RNAs did not inform the therapists if the RNAs were putting on orthotics for longer than the duration indicated on the physician's RNA orders. During an interview on 3/15/23 at 10:20 AM, the Director of Rehabilitation (DOR) stated the RNA order for splints and braces included the duration for how long a resident should wear the splint or brace. DOR stated, as tolerated meant the RNA can apply the splint or brace for less than the duration ordered because sometimes things happen and the RNA cannot apply the splint for the full time according to the physician's order. DOR stated, as tolerated did not mean that the RNA could apply the splint for more than the duration indicated in the RNA order. DOR stated the RNA order for the duration of time to apply the splint or brace was the maximum time the resident could tolerate wearing the splint/brace, because that was what was already assessed by the therapist. DOR stated the RNAs could not apply the splint/brace for longer than the duration indicated in the RNA order, because it may cause pain or skin breakdown. DOR stated that the RNAs did not report that any residents on RNA were wearing the splints/braces for longer than the physician's order for RNA. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/16/23 at 10:27 AM, RNA 1 stated there should be RNA every day of the week. RNA 1 stated RNA 1 had about 30 residents requiring RNA treatments and services a day. RNA 1 stated RNA 1 tried their best to see all residents assigned for RNA treatment but sometimes the number of residents and work was too much to see all the residents and there was not enough time to complete the work. During an interview on 3/16/23 at 10:54 AM, the Physical Therapist 1 (PT 1) stated PTs assessed residents for joint range of motion and any contractures and assessed residents to see if an orthosis was appropriate. PT 1 stated that once PT received the orthotic like a splint or brace, there was a period where PT adjusted the orthotic and assessed how the resident tolerated the orthotic. The PT usually put on an splint/brace for 30 minutes to an hour and increased in duration of wear time to assess the maximum tolerance for wearing the splint. PT 1 stated once the PT determined the maximum duration and fit for the orthotic, PT started the discharge process to an RNA program and the PTs trained the RNAs on how to put on and off the orthotic. PT 1 stated PT would inform the RNAs what the RNA order would be and informed the RNAs how long to put the orthotic on for. PT 1 stated the duration of time that was written in the order was the maximum time the resident could tolerate the orthotic and the RNAs cannot go beyond that time, because it could cause the resident more discomfort and skin breakdown. During an interview on 3/16/23 at 11:05 AM, the DOR stated it was important for residents to receive their RNA treatment and services as ordered by a physician, because it was a physician's order that needed to be carried out. DOR stated that the RNA program helped with maintaining the maximum levels that were achieved during therapy and helped to prevent further contractures. DOR stated that each resident was unique, and the RNA orders were created by a skilled therapist for that specific resident and the RNA program orders needed to be followed for each specific resident. DOR stated that if the resident's RNA treatment plan/order were not followed, then the residents were at risk for worsening of contractures, pain, skin breakdown, and decline in quality of life if the resident had further decline in function. During an interview on 3/16/23 at 2:22 PM, the Director of Staff Development (DSD) stated that it was important for residents to receive their RNA treatments and services to prevent contractures and to not lose their physical function and their ability to complete their daily activities. DSD stated it was important for residents to receive their RNA treatments as ordered so that residents did not lose their physical functioning. DSD stated she was aware that there were times where there were not enough RNAs scheduled to complete RNA treatments and stated she was aware that there were RNA treatments missed because there were not enough RNA staff scheduled in one day. A review of the facility's policy and procedures revised 6/1/21, titled, Restorative Nursing, indicated develop restorative nursing programs appropriate to the patient's identified needs. Implement the restorative nursing program according to the specifics on the care plan.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 40773 Based on observation, interview, and record review, the facility failed to ensure bed rails (also known as side rails [structural support attached to the frame of a bed and intended to prevent a patient from falling] usage was assessed and/or reassessed and an informed consent (a process in which patients are given important information, including possible risks and benefits) was obtained for the use of bed rails for two of two sampled residents (Resident 32 and Resident 135) in accordance with the facility policy by failing to: 1. Reassess Resident 32's use of bed rails since 2017. 2.a Obtain Resident 135's informed consent prior to use of bed rails. 2.b. Resident 135's bed rails assessment and reassessment indicated no bed rails to be used but observed with it. This deficient practice had the potential for Residents 32 and 135 to be at risk for Entrapment (an event in which a resident is caught, trapped, or entangled in the space in or about the bed rail) and result in an injury or harm from the use of bed rails. This also violated Resident 135's or resident representative rights to able to exercise the choice of treatment care including the use of bedrails. Findings: 1. A review of Resident 32's Admission Record indicated an initial admission to the facility on [DATE], and readmission on 1/25/17 with diagnoses of respiratory failure, tracheostomy (an opening created at the front of the neck so a tube can be inserted into the windpipe [trachea] to help you breathe), and ventilator dependence. A review of Resident 32's History and Physical, dated 6/4/21, indicated Resident 32 did not have the capacity to understand or make decisions. A review of Resident 32's Minimum Data Set (MDS, a standardized assessment and care planning screening tool), dated 1/5/23, indicated Resident 32 was totally dependent (staff provide full support) with bed mobility, dressing, eating, toilet use, and personal hygiene. Resident 32's MDS indicated bed rails not used. A review of Resident 32's Bed Rail (also known as side rails [structural support attached to the frame of a bed and intended to prevent a patient from falling]) Evaluation was last conducted on 11/23/17. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 32's Bed Rail Assessment, indicated the last reassessed was on dated 11/23/17. The Assessment indicated Resident 32 's bed rails were not used for mobility or as an enabler, and were a patient/resident representative preference. A current Bed Rail Assessment was not completed as indicated after 11/23/17. A review of Resident 32's Active Physician Orders did not indicate an order for Bed Rails. During an observation in Resident 32's room on 3/13/23 at 10:36AM, Resident 32 was observed in bed, with the head of bed up. Resident 32 was pointing at the bedside television, using her right index finger. Resident 32 was nonverbal and was observed with bilateral upper bed rails utilized. During an interview on 3/15/12 at 2:05PM, Registered Nurse (RN1) stated Resident 32 was non-verbal, bed-ridden and required total care from staff. RN1 stated Resident 32 was not able to assist staff from turning side to side and could not grab on to side rails, therefore Resident 32 could not use bed rails as an enabler (assist in facilitating movement). During an interview on 3/15/23 at 2:17PM, licensed vocational nurse (LVN2) stated when bed rails were utilized, an informed consent must be obtained prior to bed rail usage. LVN 2 stated the importance of the assessment and reassessment of bed rails was to identify if the resident still required bed rails and to assess the risk for entrapment. LVN2 stated bed rails could also be a form of restraint (a measure or condition that keeps someone or something under control or within limits) since bed rails could not be removed by the resident and by restricting resident movement. LVN 2 could not state who was responsible in completing bed rail assessments. During an concurrent interview and record review of Resident 32's Bed Rail Assessment and Reassessment on 3/15/23 at 3:02PM, the Director of Nursing (DON) stated, Resident 32's Bed Rail Assessment was not reassessed. The DON stated the process for applying bed rails to residents' beds included an assessment that was conducted upon admission and quarterly. The DON stated licensed nurses were responsible in completing bed rail assessments and that assessments and reassessments were conducted to validate the appropriateness for resident bed rails, and should be done upon admission, quarterly and as needed. The DON stated bed rails restrict movements, and also present risk for entrapments that could cause injury, therefore, informed consents, assessments and reassessments must be done. 2. A review of Resident 135's Admission Record indicated an initial admission to the facility on [DATE], and readmission on 1/19/23 with diagnoses of paraplegia (paralysis of the legs and lower body), urinary tract infection (an infection in any part of the urinary system), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). A review of Resident 135's Minimum Data Set (MDS: a standardized assessment and care planning screening tool) dated 2/28/23 indicated Resident 135 had no cognitive impairment. Resident 135 required extensive assistance (staff provide weight bearing support) with one person assist with bed mobility, toilet use, and personal hygiene. Resident 135 was totally dependent (full staff support) with dressing. Resident 135 required supervision with eating. Resident 135's MDS indicated bed rails not used. RN 1 stated never having reassessed the use of bed rails and could not state whose responsibility was it to complete the bed rail assessments. A review of Resident 135's active physician orders for 3/2023, there was no orders for bed rails indicated. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rio Hondo Subacute & Nursing Center	273 E Beverly Boulevard Montebello, CA 90640

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 135's informed consents, indicated no informed consent obtained for the use of bed rails. A review of Resident 135's Initial Bed Rail Evaluation dated 11/24/22 indicated No bed rail(s) to be used. The Evaluation indicated DO NOT USE bed rails for this resident. The Evaluation indicated head of bed elevated as a mobility enabler. A review of Resident 135's Bed Rail Evaluation dated 1/19/23 indicated No bed rail(s) to be used. During an observation In Resident 135's room on 3/13/23 at 11:06AM, Resident 135 was observed in bed with bilateral side rails up and personal belongings on each side of her bed. Resident 135 had the bed side table pulled over her bed and was watching on her tablet. During an interview on 3/13/23 at 11:07 AM, Resident 135 stated being paraplegic and had a contracted left arm. Resident 135 stated only having a functional right arm and required staff assistance to move in bed. During a concurrent interview and record review of Resident 135's informed consents on 3/16/23 at 10:05AM, the Assistant Director of Nurses (ADON) stated prior to the use of bed rails, a consent form must be signed so the Resident and/or Resident Representative was aware of the use and the reason for bed rail usage. The ADON validated no informed consent was obtained for Resident 135's bed rail usage. The ADON stated Resident 135 should not be using bed rails based on the bed rail evaluation. A review of the facility's policy titled, Side Rails, dated 6/27/22, indicated the purpose was to ensure safe use of side rails as an assistive device, to aid in mobility, or to treat medical symptoms. The policy indicated the Interdisciplinary team (IDT)- Restraint Reduction Committee would determine whether a resident should be provided with siderails on his/her bed, based on an individual assessment which included the risk for entrapment. The Policy indicated following admission and or as a resident's condition necessitates, a licensed nurse and or the IDT would complete.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 41379 Based on observation, interview, and record review, the facility failed to provide adequate and sufficient nursing staff to provide care for residents requiring Restorative Nursing Aide (RNA, nursing aide program that helps residents to maintain their function and joint mobility) services. This deficient practice had the potential for 113 residents with physician's orders for RNA to experience a decline in range of motion (ROM, full movement potential of a joint) and activities of daily living (ADL, basic activities such as eating, dressing, toileting) function. A review of the physician's order listing report for current residents on RNA dated 3/15/23 indicated 113 residents had physician's orders for RNA to provide treatments and services including but not limited to, ROM exercises to upper extremities (UE, shoulder, elbow, wrist, hand) and lower extremities (LE, hip, knee, ankle, foot), feeding program (program to assist residents to eat safely), application of splints (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) or braces (an external device to support, align, or correct a movable part of the body), ambulation (walking), and use of restorator (a type of arm or leg bicycle for exercising). A review of the facility's Nursing Staffing Assignment and Sign-In Sheet for January 2023 indicated the following RNA assignments for the 7:00 AM to 3:00 PM shift: -Sunday, 1/1/23: zero (0) RNA -Monday, 1/2/23: 0 RNA -Tuesday, 1/3/23: two (2) RNAs -Wednesday, 1/4/23: three (3) RNAs -Thursday, 1/5/23: 2 RNAs -Friday, 1/6/23: 3 RNAs -Saturday, 1/7/23: 1 RNA -Sunday, 1/8/23: 0 RNA -Monday, 1/9/23: 2 RNAs -Tuesday, 1/10/23: 3 RNAs -Wednesday, 1/11/23: 3 RNAs -Thursday, 1/12/23: 3 RNAs (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Friday, 1/13/23: 2 RNAs -Saturday, 1/14/23: 2 RNAs -Sunday, 1/15/23: 1 RNA -Monday, 1/16/23: 0 RNA -Tuesday, 1/17/23: 2 RNAs, 1 RNA orienting -Wednesday, 1/18/23: four (4) RNAs, 1 RNA orienting -Thursday, 1/19/23: 4 RNAs, 1 RNA orienting -Friday, 1/20/23: 3 RNAs -Saturday, 1/21/23: 3 RNAs, 2 RNAs orienting -Sunday, 1/22/23: 1 RNA -Monday, 1/23/23: 3 RNAs, 1 orienting -Tuesday, 1/24/23: 0 RNA -Wednesday, 1/25/23: 4 RNAs -Thursday, 1/26/23: 4 RNAs -Friday, 1/27/23: 3 RNAs -Saturday, 1/28/23: 3 RNAs, 1 RNA orienting -Sunday, 1/29/23: 1 RNA -Monday, 1/30/23: 3 RNAs -Tuesday, 1/31/23: 3 RNA A review of the facility's Nursing Staffing Assignment and Sign-In Sheet for February 2023 indicated the following RNA assignments for the 7:00 AM to 3:00 PM shift: -Wednesday, 2/1/23: 3 RNAs -Thursday, 2/2/23: 3 RNAs -Friday, 2/3/23: 3 RNAs, 1 RNA orienting -Saturday, 2/4/23: 2 RNAs, 1 RNA orienting (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/16/23 at 10:27 AM, the Restorative Nursing Assistant 1 (RNA 1) stated there should be RNA every day of the week. RNA 1 stated RNA 1 had about 30 residents requiring RNA treatments and services a day. RNA 1 stated RNA 1 tried their best to see all residents assigned for RNA treatment but sometimes the number of residents and work was too much to see all the residents and there was not enough time to complete the work. During an interview on 3/16/23 at 2:22 PM, the Director of Staff Development (DSD) stated the DSD completed the daily nurse staffing assignment and was in charge of scheduling and assigning RNAs each day. DSD stated the typical RNA schedule was in the morning shift 7 AM to 3 PM and RNA duties included completing RNA treatments and services such as ROM, ambulation, splinting, feeding program, taking resident weights, and documentation. DSD stated she was not aware of how many residents in the facility had active RNA orders and required RNA treatment. DSD stated an RNA should have around 20 residents maximum a day. DSD stated she was aware that there were times where there were not enough RNAs scheduled to complete RNA treatments and stated she was aware that residents did not receive their RNA treatments because there were not enough RNA staff scheduled in a day. DSD stated that it was important for residents to receive their RNA treatments and services to prevent contractures (loss of motion in a joint) and to not lose their physical function and their ability to complete their daily activities. During an interview on 3/16/23 at 3:08 PM, the Restorative Nursing Assistant 2 (RNA 2) stated RNA 2 had about 18 residents a day on top of helping with residents on RNA feeding program and taking admission, weekly, or monthly weights for residents. A review of the facility's policy and procedure revised 6/1/21, titled, Restorative Nursing, indicated restorative programs are coordinated by nursing .based on individual patient needs. Develop restorative nursing programs appropriate to the patient's identified needs. Implement the restorative nursing program according to the specifics on the care plan.

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on observation, interview, and record review, the facility failed to provide accurate and safe pharmaceutical services and procedures to nine of nine residents (Residents 134, 174, 9, 133, 67, 98, 68, 7 and 482) when: 1. Resident 134's lisinopril (a medicine used to treat high blood pressure and heart failure) was administered without assessing the heart rate as ordered by the physician prior to medication administration. 2. Resident 134's potassium chloride ER ([ER-Extended Release] a medicine used to prevent or treat low potassium [a mineral] levels in the body) were administered for over one year without accurate indication of its use. 3. Resident 174's Losartan Potassium (a medicine used to treat high blood pressure) was not transcribed in the Medication Administration Record (MAR) and administered from 1/21/23 to 3/13/23. 4. Resident 133 received twenty-six doses of expired Lantus (an insulin medication to manage blood sugar levels). 5. Resident 9 received six doses of expired Tylenol with Codeine #3 (a medication for pain management that is regulated by the government). 6. Resident 67 received the multivitamin liquid, and the licensed nurse did not shake the multivitamin liquid bottle before administering in accordance with the manufacturer's instruction. 7. Resident 98 was discharged , and the facility failed to ensure proper disposition of a controlled medication, Tramadol (pain medication). 8. Resident 68 received Lorazepam Oral concentrate medication (a medication which act on the brain and nerves to produce a calming effect) unrefrigerated for 16 days, against medication specifications. 9. Resident 7 received expired Humulin R insulin medication (an insulin medication to manage blood sugar levels). 10. Failed to ensure there was no duplicate active physician order for Gabapentin (a medicine used to treat partial seizures, nerve pain from shingles and restless leg syndrome) for Resident 482. These deficient practices increase the risk of the residents (Residents 134, 174, 9, 133, 67, 98, 68, 7, and 482) to adverse consequences that are not limited to severe anxiety, hypertension (high blood pressure), stroke, cardiac (heart) arrest, hyperglycemia (increase blood sugar), pain, coma, and death. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/15/2023 at 5:45 PM, the Department called an Immediate Jeopardy (IJ), a situation in which the facility's noncompliance with one or more requirements of participation had caused, or is likely to cause, serious injury, harm, impairment, or death to a resident, in the presence of the Administrator and Director of Nursing (DON) due to facility's failure to provide accurate and safe pharmaceutical services during medication administration observation. On 3/16/2023, at 7:45 PM, the Administrator and DON provided an acceptable IJ removal plan that included the following: 1. In-service was provided to all License Nurses by the Director of Nursing related to proper administration of Lisinopril to assess resident's heart rate per physician's order. 2. In-service was provided by the Director of Nursing related to potassium administration based on manufacturer's specification for Potassium ER, swallow whole do not crush or chewed, do not allow to dissolve in the mouth and must be taken containing 8 ounces (oz, a unit of measurement) of water. 3. Nurse Practitioner was informed by a licensed nurse regarding non-administration of Losartan Potassium medication, advised resident and responsible party to contact Primary Physician. In-service to Registered Nurses (RNs) to follow policy and procedures related to transcribing new medication upon admission. 4. Resident 133 expired Lantus was replaced with a new open insulin pen on 3/15/2023. In-service to all licensed nurses to follow policy and procedures related to expired medication. 5. Residents 9 expired Tylenol with Codeine #3 replaced with new Tylenol Codeine #3 on 3/15/2023. In-service to all licensed nurses to follow policy and procedures related to expired medication. 6. In-service was provided by the Director of Nursing related to proper administration of multivitamins by shaking the bottle before administration. 7. Tramadol (pain medication) controlled medication endorsed to the DON and locked in for proper disposition. In-service to all licensed nurses to follow policy and procedures related to proper disposition of controlled medications. 8. Resident 68 Lorazepam Oral concentrate was replaced with new lorazepam on 3/15/2023. In-service to all licensed nurses to properly stored as per manufacturer instructions. 9. Resident 7 expired Humulin R insulin was replaced with new Insulin vial on 3/15/2023. In-service to all licensed nurses to follow policy and procedures related to expired medication. On 3/16/23 at 8:30 PM, the Department removed the IJ after verifying and confirming onsite that the facility implemented the IJ removal plan in the presence of the Administrator and DON. Findings: (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	1. A review of Resident 134's Admission Record indicated the facility admitted Resident 134 on 9/1/2021 with diagnoses that included nonrheumatic aortic valve stenosis (narrowing of the aortic valve [part of the heart] opening), mitral valve insufficiency (a heart disease in which the valve between the left heart chambers does not close completely), diabetes mellitus, hypertension and chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should). A review of Resident 134's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 3/7/23, indicated Resident 134 had no memory and cognitive (thought process and ability to reason or make decisions) impairment. During a medication pass observation, on 3/13/23, from 9:02 AM to 9:22 AM, with Licensed Vocational Nurse (LVN) 11, in Nursing Station 2, at Medication Cart (Med Cart 2), LVN 11 prepared one tablet of Lisinopril 2.5 milligrams (mg, a unit of measurement) and LVN 11 did not assess Resident 134's heart rate before administering the Lisinopril. During an interview with LVN 11, on 3/13/23, at 10:02 AM, LVN 11 stated that Resident 134's heart rate was not checked to see if it is below 60 beats per minute prior to administering Lisinopril. LVN 11 stated, I messed up on the heart rate. LVN 11 stated that one of the consequences of not checking the heart rate before administering Lisinopril can lower the resident's heart rate even more. LVN 11 stated it is important to check the resident's blood pressure and heart rate parameters as ordered by the physician. A review of Resident 134's record, titled Order Summary Report, dated 3/13/23, indicated Lisinopril tablet 2.5 mg, ordered on 9/1/2021, give 1 tablet by mouth, one time a day for hypertension, hold for Systolic Blood Pressure (SBP, measures the pressure of your blood in your arteries [tube like structure responsible for transporting blood]) less than (<) 110 milliliters per mercury (mmHg, unit of measurement) and heart rate (HR) < 60 beats per minute (bpm, unit of measurement). A review of Resident 134's Care Plan, initiated on 9/2/2021 and revised on 10/14/2021, indicated Resident 134 exhibits or is at risk for cardiovascular symptoms or complications related to hypertension, hyperlipidemia (an excess of fats in the blood), diabetes mellitus (blood sugar problem), AKI ([Acute Kidney Injury] sudden episode of kidney failure or damage), severe aortic stenosis (heart disease), heart failure and history of septic shock (a drop in blood pressure due to an infection). The care plan intervention indicated to assess and monitor vital signs as ordered and report abnormalities to physicians. A review of facility policy and procedures, titled Administering Medications, revised date April 2019, indicated, Policy Statement: Medication are administered in a safe and timely manner, and as prescribed ., and indicated, Policy Interpretation and implementation: 7. Medications are received, labeled, stored, administered, and disposed of according to all applicable state and federal laws and consistent with standard of practice .9. The consultant pharmacist, in collaboration with dispensing pharmacy and the facility, oversees the development of procedures related to pharmacy services, including (but not limited to): c. Administration of medications . 2. During a medication pass observation, on 3/13/23, from 9:02 AM to 9:22 AM, with LVN 11, in Nursing Station 2, at Medication Cart (Med Cart 2). LVN 11 prepared and gave one tablet of Potassium Chloride Extended Release (ER), 10 milliequivalents (mEq, unit of measurement) by mouth to Resident 134. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview with RN 4 and concurrent review of the physician Order Summary Report, dated 12/27/22, 1/23/23, and 3/13/23, on 3/13/23, at 11:08 AM, the Order Summary Report indicated Potassium Chloride ER tablet extended release 10 mEq one tablet by mouth, one time a day, as a supplement for Lasix (a medication which increases urine output). RN 4 stated Resident 134 continued to receive Potassium Chloride ER after Lasix was last given and discontinued on 1/17/22. RN 4 stated, Potassium Chloride ER order should have been clarified with the physician when Lasix was discontinued on 1/17/22. The RN 4 stated the purpose of Potassium Chloride ER supplement is to replenish the resident's potassium depleted by Lasix. RN 4 stated if Potassium Chloride ER is continued without Lasix, Resident 134 can have hyperkalemia (too much potassium in your blood) which can cause symptoms like chest pain, irregular heartbeat, and hospitalization . During an interview with Resident 134, on 3/13/23, at 3:13 PM, Resident 134 stated I felt tingling on my hands for one week when I rub my hands together. During an interview with LVN 11, on 3/13/23, at 3:19 PM, LVN 11 stated if Lasix is prescribed for a resident, it should be supplemented with potassium. LVN 11 stated once Lasix is discontinued, the potassium should be discontinued depending on the resident's potassium level. During an interview with the DON, on 3/13/23, at 3:34 PM, the DON stated, the pharmacy is informed when a medication is discontinued in PCC (Point Click Care, a software for digital data of residents). The DON stated the indication for potassium in Order Summary should be updated if potassium is ordered as a supplement for Lasix and should be discontinued after Lasix is discontinued. A review of Resident 134's record, titled Order Summary Report, dated 3/13/23, indicated Potassium Chloride ER Tablet Extended Release 10 mEq was ordered on 9/01/2021, to give one tablet by mouth, one time a day, for supplement of taking Lasix. 3. A review of Resident 174's Admission Record indicated the facility admitted Resident 174 on 1/21/23, with diagnoses that included end stage renal (kidney) disease (a medical condition in which the kidneys stop working permanently leading to dialysis [a procedure to remove waste product and excess fluid from the blood] or kidney transplant [a surgery done to replace a diseased kidney with a healthy kidney from a donor]), cerebral infarct (lack of adequate blood supply to brain cells), diabetes mellitus, and hypertension. A review of Resident 174's MDS, dated [DATE], indicated Resident 174 had no memory and cognitive impairment. A review of Resident 174's Order Summary, indicated an active medication order dated 1/21/23 for Losartan Potassium Oral Tablet 50 milligram, give one tablet by mouth one time a day for hypertension, to hold for SBP < 110 mmHg and HR < 60 bpm. A review of Resident 174's MAR, dated 1/1/23 to 1/31/23, 2/1/23 to 2/28/23, and 3/1/23 to 3/31/23, indicated there was no Losartan Potassium 50 mg one (1) tablet once daily by mouth listed. During a concurrent interview and record review with Licensed Vocational Nurse (LVN) 7, on 3/13/23, at 11:56 AM, LVN 7 reviewed Resident 174's MAR on 3/13/23. LVN 7 stated there was no Losartan Potassium 50 mg 1 tab once daily by mouth transcribed in the MAR. LVN 7 stated she had never administered Losartan Potassium to Resident 174. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview with Registered Nurse (RN) 4, on 3/13/23, at 11:59 AM, RN 4 stated Losartan Potassium 50 mg 1 tablet once daily by mouth was ordered on 1/21/23 and the medication was not transcribed on the MAR from 1/1/23 to 3/31/23. RN 4 stated Losartan Potassium was not administered to Resident 174. RN 4 stated Resident 174 was a dialysis resident and the resident's blood pressure needed to be managed and controlled (by medication). RN 4 stated elevated and uncontrolled blood pressure can lead to heart problems, stroke, and death. During an interview with Resident 174, on 3/13/23, at 2:52 PM, Resident 174 stated he has a history of hypertension. Resident 174 stated he was taking Losartan Potassium for high blood pressure and reported dizziness during wheelchair transfers (to and from the bed). A review of Resident 174 record, titled Weights and Vitals Summary, indicated Resident 174 had the following blood pressure readings: - 1/23/23- 159/67 mmHg - 1/24/23 - 168/50 mmHg - 1/25/23 - 154/80 mmHg - 1/31/23 - 176/57 mmHg - 2/03/23- 160/84 mmHg (8:46 AM) - 2/03/23 - 160/78 mmHg (4:57 PM) - 2/04/23 - 160/80 mmHg - 2/05/23 - 158/89 mmHg - 2/14/23 - 176/74 mmHg - 2/15/23 - 156/60 mmHg - 2/19/23 - 160/66 mmHg (8:06 AM) - 2/19/23 - 152/64 mmHg (12:05 PM) - 2/19/23 - 159/57 mmHg (4:01 PM) - 2/20/23 - 158/89 mmHg - 2/23/23 - 158/80 mmHg - 2/24/23 - 169/67 mmHg - 2/26/23 - 159/89 mmHg (8:16 AM) (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rio Hondo Subacute & Nursing Center	273 E Beverly Boulevard Montebello, CA 90640

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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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	- 2/26/23 - 158/68 mmHg (5:52 PM) - 2/27/23 - 160/76 mmHg - 3/01/23 - 156/74 mmHg - 3/03/23 - 158/70 mmHg - 3/04/23 - 152/60 mmHg - 3/05/23 - 160/72 mmHg - 3/06/23 - 159/74 mmHg (10:46 AM) - 3/06/23 - 160/62 mmHg (6:10 PM) - 3/08/23 - 168/60 mmHg- - 3/10/23 - 160/72 mmHg - 3/11/23 - 156/68 mmHg (12:13 PM) - 3/11/23 - 160/66 mmHg (4:37 PM) - 3/11/23 - 152/62/mmHg (6:44 PM) A review of Resident 174's Care Plan initiated on 1/21/23 and revised on 1/24/23, indicated Resident exhibits or is at risk for cardiovascular symptoms or complications related to diagnosis of hypertension, bradycardia (low heart rate), hyperlipidemia and cerebrovascular accident (CVA, also known as stroke and complication of high blood pressure). The Care Plan intervention indicated To administer meds as ordered and assess for effectiveness and side effects and report abnormalities to physician. During an interview with the Registered Nurse Supervisor (RNS) on 3/13/23, at 3:07 PM, the RNS stated the RN or LVN carry out the physician order. The RNS stated, Pharmacy automatically receives medication order once order is entered in PCC. During an interview with the DON on 3/13/23, at 3:34 PM, the DON stated Licensed nurse enters physician order in PCC once order is received and confirmed. The pharmacy immediately has access to the new order once it is entered in PCC. The facility should call or fax the pharmacy to confirm if the order was received. A review of the facility's policy and procedure titled, Administering Medications, revised April 2019, indicated Policy Statement: Medication are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation: . 4. Medications are administered in accordance with prescriber orders including any required timeframe . The policy indicated the following information is checked, verified for each resident prior to administering medications: vital signs, if necessary. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of the facility's Policy and Procedure titled, Physician Orders, effective 3/22/22, indicated III. Procedures: VIII. Whenever possible, the Licensed Nurse receiving the order will be responsible for documenting and implementing the order. Medication treatment orders will be transcribed onto the appropriate resident administration record. Orders pertaining to other health care disciplines will be transcribed onto the appropriate communication system for that discipline. A review of the facility's Policy and Procedure titled, Pharmacy Services Overview, revised April 2019, indicated Policy Interpretation and Implementation: 1. Pharmaceutical services consists of: a. The process of receiving and interpreting prescriber's orders; acquiring, receiving, storing, controlling, reconciling, compounding .dispensing, packaging, labeling, distributing, administering, monitoring responses to, using and/or disposing of all medications . The policy also indicated Nursing staff communicate prescriber orders to the pharmacy and are responsible for contacting the pharmacy if a resident's medication is not available for administration. 4. A review of Resident 133's Admission Record, indicated the facility admitted the resident on 5/31/22 for osteomyelitis (bone infection), respiratory (lungs) failure, type 2 diabetes (a condition caused by high blood sugar levels that can lead to blindness, improper wound healing, and increases risk for heart attack and stroke), and pressure ulcer (injury to tissue and skin resulting from pressure on the skin). A review of Resident 133's MDS, Section C (Cognitive or mental status), dated 12/8/22, indicated Resident 133 had severely impaired cognition. During a medication pass observation, on 3/14/23, at 1:10 PM, an opened vial of Lantus was found with the name of Resident 133 and dated 1/19/23, past 28 days from open date. During an interview with LVN 6, on 3/14/23, at 1:14 PM, LVN 6 stated the Lantus was expired based on the open date and should not be in the medication cart. LVN 6 stated the medication was given to the resident daily since 1/19/23 and needed to be unexpired because residents could become hyperglycemic (increased blood sugar) from using expired Lantus. LVN 6 stated expired Lantus might not provide full strength of the medication and will not lower the resident's blood sugar. During an interview with LVN 5, on 3/16/23, at 8:42 AM, LVN 5 stated nurses must check expiration dates when administering medication because expired medications will not be as effective. LVN 5 stated Lantus expires twenty-eight days after it is opened. During an interview with RN 2, on 3/16/23 at 8:25 AM, RN 2 stated expired Lantus might not be as effective and might cause an adverse consequence or hyperglycemia. During an interview with the Director of Nursing (DON), on 3/16/23 at 8:55 AM, the DON stated, expired medications should not be given, and staff are trained on checking the medication expiration date along with the seven rights of administration and should be checking the expiration dates when administering medications. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview with the Pharmacist, on 3/16/23 at 11:13 AM, the Pharmacist stated, expired medications should not be given to residents because the efficacy may be lowered. The Pharmacist stated Lantus expires twenty-eight days after the vial is opened. Pharmacist also stated a random spot check is done on the medication carts during the monthly pharmacist visit and it is possible to miss an expired medication. A review of Resident 133 record, titled Medication Administration Record (MAR) for the month of February 2023 to March 2023, indicated Resident 133 received twenty-six expired doses of Lantus every day at 9 PM from 2/16/23 to 3/13/23. A review of Resident 133's Progress Notes, dated 3/15/23, indicated Resident 133 received expired Lantus from a vial that had been opened for more than twenty-eight days. A review of the facility policy, titled Administering Medications, with revised date April 2019, indicated the expiration date or beyond use date on the medication label is checked during medication administration and if using a multidose container, the date of opening is recorded on the container. 5. A review of Resident 9's admission record indicated the facility admitted the resident on 7/14/22 for diagnoses including congestive heart failure (heart does not pump blood as well as it should to the rest of the body), hypertension, kidney disease, dementia (condition involving impairment of brain functions like memory), and chronic pain syndrome. A review of Resident 9's Minimum Data Set Assessment Section C, dated 1/27/23, indicated Resident 9 had severely impaired cognition. During a concurrent medication storage observation and interview with LVN 7, on 3/14/23, at 4:15 PM, at Med Cart 2 on Unit 2, Resident 9's bubble pack (supply of medications with individually sealed compartments) of Tylenol with Codeine #3 (a habit-forming pain medication) with an expiration date of 3/5/23 was printed on the bubble pack of the medication. LVN 7 stated Resident 9 had an order for Tylenol with Codeine #3 to be taken as needed for moderate pain and the resident had been receiving expired medication since 3/5/23. LVN 7 stated the resident received six expired doses of Tylenol with Codeine #3 with the last dose being administered on 3/14/23. During an interview with the DON, on 3/16/23 at 8:55 AM, the DON stated expired medications should not be given and staff are trained on checking the medication expiration date along with the seven rights of administration and should be checking the expiration dates when administering medications. The DON stated checking for expired controlled medications are done during the DON's daily rounds on the units. The DON stated the expectation is for nurses to bring expired controlled medications that are no longer in use to the DON's office immediately or before the end of the day. During an interview with the Pharmacist, on 3/16/23 at 11:13 AM, the Pharmacist stated expired medications should not be given to residents because the efficacy may be lowered. Pharmacist also stated a random spot check is done on the medication carts during the monthly pharmacist visit. A review of the facility policy, Administering Medications, dated April 2019, the policy indicated the expiration date or beyond use date on the medication label is checked during medication administration and if using a multidose container, the date of opening is recorded on the container. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	6. A review of Resident 67's admission record indicated the facility admitted Resident 67 on 7/5/22 for diagnoses including chronic respiratory failure, sepsis (infection in the blood), kidney failure, anoxic brain injury (lack of oxygen to the brain), and gastroesophageal reflux disease (stomach acid backs up towards the throat and irritates the lining of the stomach and throat). A review of Resident 67's MDS, dated [DATE], indicated a test for cognition could not be completed due to impaired cognition. During an observation on 3/14/23, at 8:19 AM, LVN 6 was observed preparing multivitamin liquid for Resident 67 at Med Cart 2 and LVN 6 did not shake the multivitamin liquid bottle before administration. During an interview with LVN 6, on 3/14/23, at 1:20 PM, LVN 6 stated the multivitamin liquid was poured into the medication cup and LVN 6 was not aware of any special preparation for the multivitamin liquid. LVN 6 stated the multivitamin liquid bottle was not shaken prior to administration. LVN 6 stated it was important to follow manufacturer's instructions on the bottle to shake well prior to pouring to make sure the vitamins and minerals get dissolved and are not sitting at the bottom of the bottle and to receive the correct dose. During an interview LVN 5, on 3/16/23, at 8:42 AM, LVN 5 stated nurses must prepare medications like multivitamin liquid according to manufacturer's instructions and either shake or swirl to ensure there is equal distribution of the ingredients. During an interview with RN 2 on 3/16/23, at 8:25 AM, RN 2 stated nurses must check the manufacturer's instructions on the label to ensure proper administration of the medication. During an interview with the DON, on 3/16/23, at 8:55 AM, the DON stated that medication preparation depends on the instructions on the manufacturer's label. The DON stated that if the manufacturer's instructions on the label written to shake the bottle, then the nurse must follow the instruction prior to pouring the medication in the medication cup. 7. A review of Resident 98's admission record indicated an admission on 7/14/22 for diagnoses including acute and chronic respiratory failure, severe sepsis (infection in the blood), osteomyelitis (bone infection), and pressure ulcer Stage IV sacral region (deep injury to the tissue and skin reaching down to the bone resulting from pressure on the skin). Resident 98 was discharged to the hospital on 3/6/23. During a concurrent observation and interview with LVN 8, on 3/14/23, at 12:54 PM, a bubble pack containing tramadol (controlled pain medication) with eighteen doses with the narcotic (a drug or substance that affects mood and behavior) count sheet wrapped around the bubble pack and covered with a rubber band. Eight doses were removed from the bubble pack and eight doses were signed off on the count sheet. LVN 8 stated Resident 98 was sent to the hospital on 3/6/23 for gastrointestinal bleed and the tramadol was being held on the side of the drawer for disposal in the DON's office. LVN 8 stated the medication should have been taken to the DON's office immediately or at least by the end of the shift on 3/6/23 for proper storage and disposal. LVN 8 stated the resident last received Tramadol on 3/6/23. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview with RN 2, on 3/16/23, at 8:25 AM, RN 2 stated controlled medications are counted at change of shift and should be given to the DON as soon as the resident leaves, so they don't get stolen for personal use. During an interview with the DON, on 3/16/23, at 8:55 AM, the DON stated the nurse is to bring controlled medications to the DON office for storage. DON stated The nurse and the DON count the medications and cosign the count and the medication is held in the locked cabinet until the Pharmacist comes to witness the destruction of the controlled medication. The DON stated the expectation is for nurses to bring the controlled medications to the DON's office immediately or by the end of the shift. During an interview with the Pharmacist, on 3/16/23, at 10:21 AM, the Pharmacist stated the facility policy determines how soon the nurse should take discontinued controlled medications to the DON. The Pharmacist stated that a delay in taking the medications to the DON could result in drug diversion. A review of the facility records for Resident 98, titled Narcotic Count Sheet, indicated that eight doses were administered by the eight separate signatures and dates of administration. At the bottom of the sheet was a space designated for the balance remaining to be given to the DON or RN and it had no writings and was blank. The doses discharged and doses transferred part of Narcotic Count Sheet has no writings and were remain blank. A review of the facility policy and procedures, titled NSG 314 Disposal of Medication Waste, dated 10/24/22, indicated, the medications for discharged residents should be sent home with the resident if applicable or returned to the pharmacy when applicable or placed in a disposal bin for destruction. A review of the facility policy and procedures, titled, Pharmacy Services Overview, dated April 2019, indicated medications are stored and disposed of according to applicable laws and standards of practice. It also indicated the pharmacist and facility oversees the control of medications from point of receipt to secured storage of medications and the disposition of medications. A review of the facility policy, titled, Controlled Substances, dated April 2019, the policy indicated that controlled medication counts are completed at the end of every shift with the nurse coming on duty and the nurse going off duty. It also indicated that waste or disposal of controlled medications are done in the presence of a nurse and a witness who both sign the disposition sheet. A review of the facility policy, titled Storage of Medications, dated November 2020, indicated the discontinued medications are returned to the pharmacy or destroyed. 8. A review of Resident 68's Admission Record indicated the facility admitted Resident 68 on 1/26/22, with diagnoses that included cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area, also known as stroke) and bipolar disorder (a mental health condition that causes extreme mood swings that include emotional highs and lows). (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a medication storage observation, on 3/14/23, at 3:40 PM, found a medicine paper package labeled with Lorazepam Oral concentrate and labeled with Resident 68's name was stored in the narcotics drawer of the Medication Cart 1 of facility Station 1 at room temperature. The Lorazepam Oral Concentrate package indicated Discard 90 days after opening, and Store at cold temperature, refrigerate at 2-degree to 8-degree Celsius, No open date recorded or written on Lorazepam paper package. The bottle of Lorazepam was filled on 2/24/23. During an interview with LVN 10, on 3/14/23, at 3:55 PM, LVN 10 stated there were no open dates recorded on either the Lorazepam bottle or the paper package. LVN 10 stated this bottle of Lorazepam Oral Concentrate had been stored at room temperature in the medication cart 1 consistently and did not know when this bottle of Lorazepam was opened since there was no opening date on the bottle. LVN 10 further stated she did not know Lorazepam Oral Concentrate needed to be refrigerated after opening. A review of Resident 68's Order Summary Reports, dated 2/23 and 3/23, indicated, Resident 68 to receive Lorazepam Oral Concentrate (a medication is used to treat anxiety) 1 mg two times a day for anxiety manifested by inconsolable yelling and screaming, starting on 12/24/22. A review of Resident 68's MAR, dated 3/23, indicated, Resident 68 received Lorazepam Oral Concentrate 1 mg two times a day from 2/23 to 3/14/23. A review of Lorazepam Oral Concentrate package box and paper insert, indicated, Manufacture's Specifications for Lorazepam Oral Concentrate should be refrigerated at 2-degree Celsius to 8-degree Celsius and discard opened bottle after 90 days. During a concurrent record review and interview with LVN 10, on 3/14/23, at 4:00 PM, Resident 68's Narcotic Count Sheet, dated 3/14/23, indicated the current bottle of Lorazepam Oral Concentrate that was stored at room temperature in the Medication Cart 1 Station 1 was opened on 2/27/23. LVN 10 stated she had Resident 68 for multiple days and had been administered Lorazepam from this bottle of Lorazepam Oral Concentrate that was stored at room temperature and would lose its effectiveness if not stored in the refrigerator and would not have desired effect on Resident 68 to control his anxiety and agitation. During an interview with LVN1, on 03/16/23, at 10:39 AM, LVN 1 stated Lorazepam Liquid should be kept in the refrigerator and locked. LVN 1 stated the medication that required to be refrigerated would not be effective if it was not put in the refrigerator. LVN 1 stated the medication should be labeled with the opening date on the bottle when it was opened. During an interview with Director of Staff Development (DSD), on 3/16/23, at 10:49 AM, the DSD stated, If a medication was required to be refrigerated but was stored at room temperature, the potency of the medication would be affected and should not be given to residents. The DSD stated medication should be labeled with opening date on the bottle when it was opened. 9. A review of Resident 7's Admission Record indicated the facility admitted Resident 7 on 2/7/23 with diagnoses that included Type II diabetes mellitus and bipolar disorder (a mental health condition that causes extreme mood swings that include emotional highs and lows). (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of Resident 7's MDS, dated [DATE], indicated Resident 7 had severely impaired memory and cognition. Resident 7 required limited assistance (resident highly involved in activity, staff provide guided maneuvering of limbs or other non-weight-bearing assistance) wit [TRUNCATED]

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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** 31333 Based on interview and record review, the facility failed to perform a thorough monthly Medication Regimen Review (MRR) and to act upon recommendations made by the contracted pharmacist (CP) regarding medication therapy for four out of five sampled residents (Resident 134, Resident 154, Resident 482, and Resident 174). (Cross Reference to F759 and F760) These deficient practices of failing to identify medications not administered in accordance with the physician's orders increased the risk for inadequate control of Resident 134 and Resident 174's blood pressure; inadequate management of Resident 134's dry eyes; and the failure to identify irregularities in the order and use of CBD Oil (Cannabidiol (CBD) is an oil derived from the cannabis plant. Possible health benefits include reducing inflammation and pain) for Resident 154; and inadequate management of Resident 482's seizure that can lead to serious illness or injury. Findings: 1. A record review of Resident 174's Admission Record indicated the facility admitted Resident 174 on 1/21/23 with diagnoses that included end stage renal disease (a medical condition in which the kidneys stop working permanently leading to dialysis or kidney transplant), cerebral infarct (lack of adequate blood supply to brain cells), diabetes mellitus, and hypertension (high blood pressure). A record review of Resident 174's Minimum Data Set (MDS - a care and assessment screening tool) dated 1/27/23, indicated the resident had no cognitive (thought process and ability to reason or make decisions) impairment. During a concurrent interview and record review on 3/13/23 at 11:59 AM, with Registered Nurse (RN 4), Resident 174's Order Summary Report, dated 1/26/23 and 03/13/23, and Resident 174's Medication Admission Record (MAR, a document containing medical and demographic information), dated for the months of 1/23, 02/23, and 3/23, were reviewed indicating: a. An Order Summary Report for the resident to receive Losartan (treat high blood pressure) Oral Tablet 50 mg, give one tablet by mouth one time a day for hypertension, hold for systolic blood pressure (SBP [measures the pressure in your arteries when your heart beats] less than 110 mmHg (millimeters of mercury, unit of measure) or heart rate (HR) less than 60 (beats per minute) with an order date of 1/21/23. b. Resident 174's MARs, dated 1/23 through 3/23, did not include the physician order for Losartan medication. RN 4 verified Resident 174's Losartan order dated 1/21/23 in the Pointclickcare (PCC, a web-based electronic health records software utilized by the Facility). RN 4 reviewed Resident 174's MAR for the months of 1/23, 2/23, and 3/23 and stated the order for Losartan was not documented on the resident's MAR between 1/23 through 3/23. RN 4 stated there was no documentation that Resident 174 was administered the Losartan medication since it was ordered on 1/21/23. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Director of Nursing (DON), on 3/13/23, at 3:34 PM, the DON stated licensed nurses enter physician orders in PCC once the order is received and confirmed. The DON stated when a medication order is placed in PCC it is automatically transcribed (put into written or printed form) in the MAR. The DON verified that pharmacy immediately has access to the new order once it is entered in PCC. During an interview on 3/16/23, at 10:05 AM, with the facility's Consultant Pharmacist (Pharmacist), Pharmacist stated, she reviews each resident's clinical records at the facility once a month. The Pharmacist stated she spot checks (to sample or investigate quickly or at random) the physician orders placed in the PCC against the transcription or recap (reviewing the MAR against the physician's orders to ensure accuracy) of the orders but does not review 100 percent. The new order for Resident 174's blood pressure medication was missed and should have been followed up. A review of the Monthly Regimen Review (MRR) reports titled, Consultation Report, dated, 2/01/23 through 2/28/23 indicated . the resident's medication regimen contained no new irregularities .No recommendation, for Resident 174. The Pharmacist failed to identify and report the omission of an ordered medication, Losartan which was ordered for Resident 174 on 1/21/23 and not administered for two months. A review of the facility's Policy and Procedure (P&P) titled Medication Regimen Review (MRR) dated 05/19, indicated, The MRR involves a thorough review of the resident's medical record to prevent, identify, report, and resolve medication related problems, medication errors and irregularities, for example . omissions of ordered medications .other medication errors, including those related to documentation. 2. A record review of Resident 134's Admission Record indicated the facility admitted Resident 134 on 9/01/21 with diagnoses that included nonrheumatic aortic valve stenosis (narrowing of the aortic valve opening), mitral valve insufficiency (a disease in which the valve between the left heart chambers doesn't close completely), diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), hypertension (high blood pressure), and chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should). A record review of Resident 134's MDS dated [DATE], indicated Resident 134 had no cognitive impairment. During a record review on 3/13/23, with RN 4 at 10:48 AM, Resident 134's Order Summary Report for the months of 12/22, 1/23, 2/23, and 3/23 and Resident 134's written and telephone orders (T.O.) were reviewed indicating: a. An Order Summary Report, dated 03/13/23, included an order for the resident to receive Potassium Chloride ER Tablet Extended Release 10 milliequivalents (mEq, a unit of measure), give 1 tablet by mouth one time a day for supplement of taking Lasix, order date of 09/01/21. b. Resident 134's T.O. included the following: Lasix 40 milligram (mg, a unit of measure), give one tablet by mouth one time a day for hypertension. Hold for SBP less than 110 mmHg, order date 9/01/21. The order for Lasix was changed on 10/20/21 to; (continued on next page)

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Rio Hondo Subacute & Nursing Center	273 E Beverly Boulevard Montebello, CA 90640

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Lasix 40 mg, give one tablet by mouth every other day for edema for 90 days, order dated 10/20/21 c. Resident 134's written physician order dated 1/12/23 indicated a new order for Artificial Tears eyedrops, to instill one drop into both eyes twice a day for one week; then one drop into both eyes twice a day as needed (PRN) for dry eyes and contusion (when blood vessels around the eye are damaged or broken after an injury) to right eye. During a concurrent interview and record review on 3/13/23 at 10:55 AM with RN 4, Resident 134's physician orders and administration through the PCC system were reviewed. RN 4 stated the resident was ordered Potassium ER to be taken while on Lasix. RN 4 stated Resident 134's was no longer taking Lasix since 1/19/22. RN 4 stated Resident 134's physician should have been contacted right away when Potassium continued to be administered to the resident once Lasix was discontinued a year ago (01/22). During a concurrent interview and record review on 03/13/23 at 11:23 AM with RN 4, Resident 134's physician orders was reviewed. RN 4 stated Resident 134's order for Artificial Tears was changed on 1/12/23 from two drops in the right eye three times a day to one drop into both eyes twice a day. RN 4 Resident 134's order for Artificial Tears dated 1/12/23 was never put into the PCC system. RN 4 stated, the facility is not following the physician's plan of care for Resident 134. During an interview on 3/16/23, at 11:00 AM, with the facility's Consultant Pharmacist (Pharmacist), Pharmacist stated, I made no recommendations regarding resident (Resident 134). Pharmacist stated continuing Resident 134 on Potassium ER after Lasix was discontinued is a clinical aspect that should have been reviewed. A review of the PCC indicated Pharmacist documented in the PCC review of Resident 134's clinical record 15 times between 2/23/22 through 2/22/23 with no documentation the new order for Artificial Tears on 1/12/23 and the continued administration of Potassium after Lasix was discontinued during the month of 1/22 were identified as irregularities. A review of the facility's Policy and Procedure (P&P) titled Medication Regimen Review (MRR) dated 05/19, indicated, The MRR involves a thorough review of the resident's medical record to prevent, identify, report, and resolve medication related problems, medication errors and irregularities, for example . omissions of ordered medications .incorrect medications, administration times or dosage forms; or other medication errors, including those related to documentation. 3. A review of Resident 154's Admission Record indicated the facility admitted Resident 154 on 9/6/2022 with diagnoses that included acute and chronic respiratory failure (a serious condition that makes it difficult to breathe on your own), cerebral edema (swelling in the brain), metabolic encephalopathy (changes of chemicals in the brain that can lead to confusion or other brain dysfunctions), dependence on respirator ventilator (breathing machine) and impaired cognitive ability. A review of Resident 154's Order Summary Report dated 12/27/2022 and signed by a prescriber on 12/29/22 included an order for CBD oil, administer 10 drops daily sublingually (under the tongue) for mentation improvement, order date 10/26/22. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/16/23, at 11:23 AM, with Pharmacist, Pharmacist stated, she was not aware Resident 154 was ordered and administered CBD Oil at the facility. The Pharmacist stated the facility nurses should not be administering the CBD Oil to the resident. During an interview on 03/16/23, at 06:26 PM with DON, DON stated the CBD Oil physician order was placed in PCC and the facility's Consultant Pharmacy will see the order. The DON stated Pharmacist should be reviewing all medications for the residents in the facility including prescription and over-the-counter medication orders. The DON stated Pharmacist can see all orders placed in the PCC. During an interview on 3/16/23, at 06:37 PM with RN 2, RN 2 stated, I have seen the pharmacist come and check the medication carts and they have never discussed or clarified the CBD Oil storage, prescription order, or the resident it was to be used for. RN 2 stated the pharmacy was the first people we contacted regarding the CBD Oil for guidance. RN 2 stated we (facility nursing staff) would have made a better decision if we had been provided the information. A review of the facility's Policy and Procedure (P&P) titled Medication Regimen Review (MRR) dated 05/19, indicated, The MRR involves a thorough review of the resident's medical record to prevent, identify, report, and resolve medication related problems, medication errors and irregularities . - Within 24 hours of the MRR, the Consultant Pharmacist provides a written report to the attending physician for each resident identified as having a non-life-threatening medication irregularity .An irregularity refers to the use of medication that is inconsistent with accepted pharmaceutical services standards of practice; is not supported by medical evidence . - If the identified irregularity represents a risk to a person's life, health, or safety, the Consultant Pharmacist contacts the physician immediately (within one hour) to report the information to the physician verbally, and documents the notification . - If the Physician does not provide a timely or adequate response, or the Consultant Pharmacist identifies that no action has been taken, he/she contacts the Medical Director or (if the Medical Director is the physician of record) the Administrator. - The Consultant Pharmacist provides the Director of Nursing Services and Medical Director with a written, signed and dated copy of all medication regimen reports. 42878 4. A review of Resident 482's Admission Record indicated the resident was originally admitted to the facility on [DATE] and then readmitted on [DATE] with diagnosis that included, metabolic encephalopathy (a condition in which brain function is disturbed either temporarily or permanently),type 1 diabetes mellitus (a chronic condition in which the pancreas produces little or no insulin with diabetic polyneuropathy(a condition in which a person's peripheral nerves are damaged) major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily functioning). A review of Resident 482's History and Physical (H&P) dated 3/09/2023 indicated the resident has fluctuating capacity to understand and make decisions. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 3/01/2023, indicated Resident 482 required two- person assist and total dependence (full staff performance every time) for bed mobility. The MDS indicated Resident 482 requires one-person assist with total dependance for dressing, toilet use, personal hygiene. A review of Resident 482's Physician Orders for the month of March,2023, included an order for the resident to receive Depakote (Divalproex Sodium give 1 tablet by mouth two times a day for Schizoaffective disorder, Bipolar type manifested by rapid mood cycling as evidence by sudden shifts in mood from pleasant to extreme anger. A review of the Consultation Review, dated 1/24/23, indicated the contracted pharmacist made a recommendation to reduce Divalproex Sodium Dr 250 mg every night with the end goal of discontinuation. A review of Resident 482's clinical record from 1/24/23 to 3/16/23 indicated no response from Resident 482's attending physician regarding the pharmacist's recommendation listed above and no goal to discontinue the medication as recommended by the CP. During an interview and concurrent record review on 3/16/23 at 5:15 PM with the Director of Nurses (DON), the DON confirmed there was no documented clinical record from 1/24/23 to 3/16/23 indicating the facility had informed Resident 482's physician of the consultant pharmacist recommendation. A review of the facility's policy Medication Regimen Reviews, revised May 2019, indicated The attending physician documents in the medical record that the irregularity had been reviewed and what (if any) action was taken to address it. 46919

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40773 Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 65) was free from an unnecessary psychotropic drug (any medication capable of affecting the mind, emotions, and behavior) by not having a summarized tally of the resident's behavior each month for the use of Lexapro (medication used to treat depression [mood disorder that causes a persistent feeling of sadness and loss of interest]) from March 2022 to February 2023, as indicated in the facility policy and procedure. This deficient practice had the potential to place Resident 65 at risk for significant adverse (harmful) consequences from the use of unnecessary psychotropic drug. Findings: A review of Resident 65's Admission Record indicated an initial admission to the facility on [DATE], and readmission on 1/20/23 with diagnoses of hypertension (high blood pressure), diabetes (high blood sugar) and depression. A review of Resident 65's Minimum Data Set (MDS, a standardized assessment and care planning screening tool) dated 2/3/23 indicated Resident 65 had no cognitive (person's ability to think, learn, remember, use judgement, and make decisions) impairment. The MDS indicated Resident 65 did not have behaviors. The MDS indicated Resident 65 required extensive assistance (staff provide weight bearing support) with one person assist with bed mobility, dressing, toilet use, and personal hygiene. The MDS indicated Resident 65 was on an antidepressant (medication used to treat depression) medication within the last seven (7) days. A review of Resident 65's 1/2023 Order Summary Report indicated an order for Lexapro 12.5 milligrams (mg-a unit of measurement) PO daily for depression manifested by (M/B) verbalization for sadness, ordered 1/20/22. A review of Resident 65's Order Summary Report indicated an order for Lexapro 10 mg PO daily for depression M/B verbalization for sadness, ordered 1/20/23. A review of Resident 65's Care Plan for Psychotropic Medication for Lexapro, initiated 1/23/23 indicated to administer Lexapro 15mg as ordered for verbalization of sadness. The Care Plan indicated to monitor for continued need of medication as related to behaviors and mood. The Care Plan interventions were to obtain psychiatric evaluation as ordered and to provide an informed consent to Resident 65. A review of Resident 65's active Physician Orders for 03/2023 indicated an order dated 3/8/23 to: 1. Monitor side effects related to Lexapro 15mg daily (QD): Sedation, Drowsiness, Dry Mouth, Blurred Vision, Urinary Retention, Tachycardia, Muscle Tremor, Agitation, Headache, Skin Rash, Photosensitivity (skin) Excess Weight Gain. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Monitor episodes of verbalization of sadness for Lexapro 15mg QD Q Shift & Tally by hashmarks. Document non-Pharma Interventions use. 1.Removed patient from Environment. 2.Redirected by engagement in alternative activity. 3.Listened to patient, attempted to calm Familiarized patient with belongings/ surroundings. 4.Toileted patient. 5.Ambulated patient. 6.Escorted patient to room for reduced stimuli. 7.Provided patient with food/drink. During concurrent observation and interview in Resident 65s room on 3/13/23 at 12:29PM, Resident 65 was observed seated on his wheelchair beside his bed. Resident 65 was well groomed and had personal belongings organized in his room on a dresser and in boxes. Resident 65 stated not being able to sleep during the nighttime and sleeps more during the day. During an interview on 3/15/23 at 10:56AM, licensed vocational nurse 4 (LVN4) stated Resident 65 was administered Lexapro during the evening shift (3-11PM). LVN4 stated Resident 65 was very verbal and does not mention any verbalization of sadness during the morning shift (7-3pm) to LVN4. LVN4 stated other behaviors of depression could be when a resident sleeps more than usual or could be a lack of sleep. LVN 4 stated only documentation of verbalization of sadness from Resident 65 were documented on the MAR. During an interview on 3/15/23 at 11AM, certified nurse assistant 2 (CNA2) stated Resident 65 does not verbalize being sad but does notice Resident 65 sleeping a lot. During a concurrent observation and interview in Resident 65's room on 3/16/23 at 8:21AM, Resident 65 was observed laying in bed with his right hand on his forehead and eyes closed. Resident 65 acknowledged he was on antidepressants but could not state how many milligrams Resident 65 was administered. Resident 65 stated I just don't know how much I am on anymore. Resident 65 stated he does not verbalize to facility staff his sadness and that he goes out of the facility to visit his therapist. During a concurrent interview and record review of Resident 65's MAR on 3/16/23 at 9:25AM, the ADON stated Resident 65 did not have documented episodes of verbalization of sadness in 01/2023, 02/2023, and 03/2023, and that only the verbal response of Resident 65 would be considered a behavior, and no other behaviors of sadness exhibited by Resident 65 would be documented. The ADON stated documented behaviors were important since it was the justifying factor for the use and need to, increase, decrease or remain on the same medication dosage. The ADON could not state why Resident 65's Lexapro was increased to 15mg on 3/2/23. During a concurrent record review of Resident 65's Behavior Monthly Summary for Lexapro 10mg daily manifested by verbalization of sadness and interview on 3/16/23 at 9:30AM, the ADON acknowledged that Resident 65's 2022's March, April, May, June, July, August, September, October, November, and December monthly behaviors were not tallied at the end of the month. The ADON stated monthly behaviors were recorded to indicate how many episodes Resident 65 has had for the month, and to identify if there had been an increase or decrease, and to identify the effectiveness or effectiveness of the Lexapro. During a concurrent record review of Resident 65's Behavior Monthly Summary for Lexapro 15 mg daily manifested by verbalization of sadness and interview on 3/16/23 at 9:31AM, the ADON acknowledged no tallies were completed from January and February 2023. The ADON stated licensed nurses should tally at the end of the month how many behaviors Resident 65 had, to track if behaviors were increasing or decreasing. (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 the facility's Policy and Procedure, titled, Psychoactive Drug Management, revised 9/20/22, monthly occurrence of the behaviors would be tallied and entered on the Monthly Psychoactive Drug Management Form.

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F 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five percent (%). Five medication errors out of 29 total opportunities contributed to an overall medication error rate of 17.24 % affecting three of three residents (Residents 174, 134, and 67) observed for medication administration. The medication errors were as follows: 1. Resident 174 failed to receive the physician order of Losartan Potassium (a medicine used to treat high blood pressure) from [DATE] to [DATE]. 2. Resident 134 received the physician order of Potassium Chloride ER ([ER-Extended Release] a medicine used to prevent or treat low potassium [a mineral] levels in the body) for over one year without adequate indication for its use. 3. Resident 134's physician ordered parameters to hold for Systolic Blood Pressure (SBP, measures the pressure of your blood in your arteries [tube like structure responsible for transporting blood]) less than (<) 110 milliliters per mercury (mmHg, unit of measurement) and heart rate (HR) < 60 beats per minute (bpm, unit of measurement) was not obtained prior to the administration of Lisinopril (a medicine used to treat high blood pressure and heart failure). 4. Resident 134 did not receive one drop of Artificial Tears Solution (a medicine used to relieve dry, irritated eyes) for both eyes per physician's order. 5. Resident 67 received the multivitamin liquid from a bottle that was not shaken prior to administration per manufacturer's instruction. These deficient practices had the potential to result in serious medical complications such as severe weakness, eye irritation, blindness, high blood pressure, stroke (occurs when something blocks blood supply to part of the brain or when a blood vessel in the brain bursts), hyperkalemia (increase potassium, a supplement, in the blood) chest pain, cardiac (heart) arrest, hospitalization , and or death. On [DATE] at 5:45 PM, the Department called an Immediate Jeopardy (IJ), a situation in which the facility's noncompliance with one or more requirements of participation had caused, or is likely to cause, serious injury, harm, impairment, or death to a resident, in the presence of the Administrator and Director of Nursing (DON) due to facility's failure to ensure that its medication error rate was less than five percent (%) during medication administration observation. On [DATE], at 7:45 PM, the Administrator and DON provided an acceptable IJ removal plan that included the following: 1. The Nurse Practitioner was informed by a licensed nurse regarding non-administration of Losartan Potassium medication, advised resident and responsible party to contact Primary Physician. In-service to Registered Nurses (RNs) to follow policy and procedures related to transcribing new medication upon admission. (continued on next page)

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F 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. In-service was provided by the Director of Nursing related to potassium administration based on manufacturer's specification for Potassium ER, swallow whole do not crush or chewed, do not allow to dissolve in the mouth and must be taken containing 8 ounces (oz, a unit of measurement) of water. 3. In-service was provided to all License Nurses by the Director of Nursing related to proper administration of Lisinopril to assess resident heart rate per physician's order. 4. Resident 134 Artificial tears replaced with a new Artificial Tears on [DATE]. In-service to all licensed nurses to follow policy and procedures related to expired medication. 5. In-service was provided by the Director of Nursing related to proper administration of Multivitamins by shaking the bottle before administration. On [DATE] at 8:30 PM, the Department removed the IJ after verifying and confirming onsite that the facility implemented the IJ removal plan in the presence of the Administrator and DON. Findings: 1. A review of Resident 174's Admission Record indicated the facility admitted Resident 174 on [DATE], with diagnoses that included end stage renal (kidney) disease (a medical condition in which the kidneys stop working permanently leading to dialysis [a procedure to remove waste product and excess fluid from the blood] or kidney transplant [a surgery done to replace a diseased kidney with a healthy kidney from a donor]), cerebral infarct (lack of adequate blood supply to brain cells), diabetes mellitus (blood sugar problem), and hypertension (high blood pressure). A review of Resident 174's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated [DATE], indicated Resident 174 had no memory and cognitive (thought process and ability to reason or make decisions) impairment. A review of Resident 174's Order Summary, indicated an active medication order dated [DATE] for Losartan Potassium Oral Tablet 50 milligram (mg, as unit of measurement), give one tablet by mouth one time a day for hypertension, hold for SBP < 110 mmHg or HR < 60 bpm. A review of Resident 174's Medication Administration Record (MAR), dated [DATE] to [DATE], [DATE] to [DATE], and [DATE] to [DATE], indicated there was no Losartan Potassium 50 mg one (1) tablet once daily by mouth listed. During a concurrent interview and record review with Licensed Vocational Nurse (LVN) 7, on [DATE], at 11:56 AM, LVN 7 reviewed Resident 174's MAR on [DATE]. LVN 7 stated there was no Losartan Potassium 50 mg 1 tab once daily by mouth transcribed in the MAR. LVN 7 stated she had never administered Losartan Potassium to Resident 174. During an interview with Registered Nurse (RN) 4, on [DATE], at 11:59 AM, RN 4 stated Losartan Potassium 50 mg 1 tablet once daily by mouth was ordered on [DATE] and the medication was not transcribed on the MAR from [DATE] to [DATE]. RN 4 stated Losartan Potassium was not administered to Resident 174. RN 4 stated Resident 174 was a dialysis resident and the resident's blood pressure needed to be managed and controlled (by medication). RN 4 stated elevated and uncontrolled blood pressure can lead to heart problems, stroke, and death. (continued on next page)

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F 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview with Resident 174, on [DATE], at 2:52 PM, Resident 174 stated he has a history of hypertension. Resident 174 stated he was taking Losartan Potassium for high blood pressure and reported dizziness during wheelchair transfers (to and from the bed). A review of Resident 174 record, titled Weights and Vitals Summary, indicated Resident 174 had the following blood pressure readings: - [DATE]- ,d+[DATE] mmHg - [DATE] - ,d+[DATE] mmHg - [DATE] - ,d+[DATE] mmHg - [DATE] - ,d+[DATE] mmHg - [DATE]- ,d+[DATE] mmHg (8:46 AM) - [DATE] - ,d+[DATE] mmHg (4:57 PM) - [DATE] - ,d+[DATE] mmHg - [DATE] - ,d+[DATE] mmHg - [DATE] - ,d+[DATE] mmHg - [DATE] - ,d+[DATE] mmHg - [DATE] - ,d+[DATE] mmHg (8: 06 AM) - [DATE] - ,d+[DATE] mmHg (12:05 PM) - [DATE] - ,d+[DATE] mmHg (4:01 PM) - [DATE] - ,d+[DATE] mmHg - [DATE] - ,d+[DATE] mmHg - [DATE] - ,d+[DATE] mmHg - [DATE] - ,d+[DATE] mmHg (8:16 AM) - [DATE] - ,d+[DATE] mmHg (5:52 PM) - [DATE] - ,d+[DATE] mmHg - [DATE] - ,d+[DATE] mmHg - [DATE] - ,d+[DATE] mmHg (continued on next page)

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F 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- [DATE]- ,d+[DATE] mmHg - [DATE] - ,d+[DATE] mmHg - [DATE] - ,d+[DATE] mmHg (10:46 AM) - [DATE] - ,d+[DATE] mmHg (6:10 PM) - [DATE] - ,d+[DATE] mmHg - [DATE] - ,d+[DATE] mmHg - [DATE] - ,d+[DATE] mmHg (12:13 PM) - [DATE] - ,d+[DATE] mmHg (4:37 PM) - [DATE] - ,d+[DATE]/mmHg (6:44 PM) A review of Resident 174's Care Plan initiated on [DATE] and revised on [DATE], indicated Resident exhibits or is at risk for cardiovascular (refers to heart and blood vessel disease) symptoms or complications related to diagnosis of hypertension, bradycardia (low heart rate), hyperlipidemia (high fats in the blood), and cerebrovascular accident (CVA, also known as stroke and complication of high blood pressure). The Care Plan intervention indicated, To administer meds as ordered and assess for effectiveness and side effects and report abnormalities to physician. During an interview with the Registered Nurse Supervisor (RNS) on [DATE], at 3:07 PM, the RNS stated the RN or LVN carry out the physician order. The RNS stated, Pharmacy automatically receives medication order once order is entered in PCC (Point Click Care, a software for digital data of residents). During an interview with the DON on [DATE], at 3:34 PM, the DON stated Licensed nurse enters physician order in PCC once order is received and confirmed. The pharmacy immediately has access to the new order once it is entered in PCC. The facility should call or fax the pharmacy to confirm if the order was received. 2. A review of Resident 134's Admission Record indicated the facility admitted Resident 134 on [DATE] with diagnoses that included nonrheumatic aortic valve stenosis (narrowing of the aortic valve [part of the heart] opening), mitral valve insufficiency (a heart disease in which the valve between the left heart chambers does not close completely), diabetes mellitus, hypertension and chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should). A review of Resident 134's MDS, dated [DATE], indicated Resident 134 had no memory and cognitive impairment. During a medication pass observation, on [DATE], from 9:02 AM to 9:22 AM, with LVN 11, in Nursing Station 2, at Medication Cart (Med Cart 2). LVN 11 prepared and gave one tablet of Potassium Chloride Extended Release (ER), 10 milliequivalents (mEq, unit of measurement) by mouth to Resident 134. (continued on next page)

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F 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview with RN 4, on [DATE], at 11:08 AM, and concurrent review of the physician Order Summary Report, dated [DATE], [DATE], and [DATE], indicated Potassium Chloride ER tablet extended release 10 mEq one tablet by mouth, one time a day, as a supplement for Lasix (a medication which increases urine output). RN 4 stated Resident 134 continued to receive Potassium Chloride ER after Lasix was last given and discontinued on [DATE]. RN 4 stated, Potassium Chloride ER order should have been clarified with the physician when Lasix was discontinued on [DATE]. The RN 4 stated the purpose of Potassium Chloride ER supplement is to replenish the resident's potassium depleted by Lasix. RN 4 stated if Potassium Chloride ER is continued without Lasix, Resident 134 can have hyperkalemia which can cause symptoms like chest pain, irregular heartbeat, and hospitalization . During an interview with Resident 134, on [DATE], at 3:13 PM, Resident 134 stated I felt tingling on my hands for one week when I rub my hands together. During an interview with LVN 11, on [DATE], at 3:19 PM, LVN 11 stated if Lasix was prescribed for a resident, it should be supplemented with potassium. LVN 11 stated once Lasix was discontinued, the potassium should be discontinued depending on the resident's potassium level. During an interview with the DON, on [DATE], at 3:34 PM, the DON stated, The pharmacy is informed when a medication is discontinued in PCC (Point Click Care, a software for digital data of residents). The DON stated, Indication for potassium in Order Summary should be updated if potassium is ordered as a supplement for Lasix and should be discontinued after Lasix is discontinued. A review of Resident 134's Order Summary, dated [DATE], indicated Lasix 40 mg 1 tablet by mouth one time a day for hypertension was initially ordered on [DATE] and changed on [DATE] to Lasix 40 mg 1 tablet by mouth, one time only for edema for 1 day, and give 1 tablet by mouth, one time a day every other day for edema for 90 days (Wednesday, Friday, Sunday). A review of Resident 134's record, titled Order Summary Report, dated [DATE], indicated Potassium Chloride ER Tablet Extended Release 10 mEq was ordered on [DATE], to give one tablet by mouth, one time a day, for supplement of taking Lasix. A review of Resident 134's MAR, dated [DATE] to [DATE], indicated Lasix 40 mg was last administered on [DATE]. There was no order to discontinue Potassium Chloride ER which was a supplement to Lasix. A review of Resident 134's MAR, dated [DATE] to [DATE], [DATE] to [DATE], [DATE] to [DATE], and [DATE] to [DATE], indicated Resident 134 received Potassium Chloride ER tablet extended release 10 mEq one tablet daily. 3. During a medication pass observation, on [DATE], from 9:02 AM to 9:22 AM, with LVN 11, in Nursing Station 2, at Medication Cart (Med Cart 2), LVN 11 prepared one tablet of Lisinopril 2.5 mg and LVN 11 did not assess Resident 134's heart rate before administering the Lisinopril. During an interview with LVN 11, on [DATE], at 10:02 AM, LVN 11 stated that Resident 134's heart rate was not checked to see if it is below 60 beats per minute prior to administering Lisinopril. LVN 11 stated I messed up on the heart rate. LVN 11 stated that one of the consequences of not checking the heart rate before administering Lisinopril can lower the resident's heart rate even more. LVN 11 stated it is important to check the resident's blood pressure and heart rate parameters as ordered by the physician. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056487	A. Building B. Wing	03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rio Hondo Subacute & Nursing Center	273 E Beverly Boulevard Montebello, CA 90640

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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 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of Resident 134's record, titled Order Summary Report, dated [DATE], indicated Lisinopril tablet 2.5 mg, ordered on [DATE], give 1 tablet by mouth, one time a day for hypertension, hold for SBP <110 and HR<60. 4. During a medication pass observation, on [DATE], from 9:02 AM to 9:22 AM, with LVN 11, in Nursing Station 2, at Med Cart 2, LVN 11 administered to Resident 134, Artificial Tears Solution 1% (Carboxymethylcellulose Sodium) 2 drops in right eye three times a day for redness. A review of Resident 134's record, titled Order Summary Report, dated [DATE], indicated, on [DATE], the physician ordered Artificial Tears Solution 1%, 2 drops in right eye three times a day. A review of Resident 134's Physician's Telephone Orders, dated [DATE], indicated Artificial Tears Eye Drops 1 drop OU (both eyes) BID (twice daily) for 1 week then 1 drop OU BID PRN (as needed) for dry eyes and contusion to the right eye. A review of Resident 134's MAR, dated [DATE] to [DATE], indicated Artificial Tears Solution 1% 2 drops in right eye three times daily was administered for Resident 134 from [DATE] to [DATE]. No administration record of Artificial Tears Eye Drops, 1 drop OU BID for 1 week, then 1 drop OU BID PRN. During an interview with RN 4, on [DATE], at 10:48 AM, RN 4 stated the physician order dated [DATE] was not transcribed to the MAR and not getting the eye drop on both eyes would cause harm and discomfort to the untreated eye. A review of the facility's Policy and Procedure titled, Physician Orders, effective [DATE] indicated III. Procedures: VIII. Whenever possible, the Licensed Nurse receiving the order will be responsible for documenting and implementing the order. 5. A review of Resident 67's admission record indicated the facility admitted Resident 67 on [DATE] for diagnoses including chronic respiratory (lungs) failure, sepsis (infection in the blood), kidney failure, anoxic brain injury (lack of oxygen to the brain), and gastroesophageal reflux disease (stomach acid backs up towards the throat and irritates the lining of the stomach and throat). A review of Resident 67's MDS, dated [DATE], indicated a test for cognition could not be completed due to impaired cognition. During an observation on [DATE], at 8:19 AM, LVN 6 was observed preparing multivitamin liquid for Resident 67 at Med Cart 2 and did not shake the multivitamin liquid bottle before administration. During an interview with LVN 6, on [DATE], at 1:20 PM, LVN 6 stated the multivitamin liquid was poured into the medication cup and LVN 6 was not aware of any special preparation for the multivitamin liquid. LVN 6 stated the multivitamin liquid bottle was not shaken prior to administration. LVN 6 stated it was important to follow manufacturer's instructions on the bottle to shake well prior to pouring to make sure the vitamins and minerals get dissolved and are not sitting at the bottom of the bottle and to receive the correct dose. During an interview LVN 5, on [DATE], at 8:42 AM, LVN 5 stated nurses must prepare medications like multivitamin liquid according to manufacturer's instructions and either shake or swirl to ensure there is equal distribution of the ingredients. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rio Hondo Subacute & Nursing Center	273 E Beverly Boulevard Montebello, CA 90640

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F 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview with RN 2 on [DATE], at 8:25 AM, RN 2 stated nurses must check the manufacturer's instructions on the label to ensure proper administration of the medication. During an interview with the DON, on [DATE], at 8:55 AM, the DON stated that medication preparation depends on the instructions on the manufacturer's label. The DON stated that if the manufacturer's instructions on the label written to shake the bottle, then the nurse must follow the instruction prior to pouring the medication in the medication cup. A review of the facility's policy and procedure titled, Administering Medications, revised [DATE], indicated Policy Statement: Medication are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation: . 4. Medications are administered in accordance with prescriber orders including any required timeframe . 47331

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on observation, interview, and record review, the facility failed to ensure seven of seven sampled residents (Residents 174, 134, 133, 7, 9, 68 and 482) in Stations 1, 2, and subacute unit to be free from significant medication errors when: 1. Resident 174, a dialysis (a procedure to remove waste product and excess fluid from the blood) resident, did not receive Losartan Potassium (a medicine used to treat high blood pressure) for 52 days from 1/21/23 to 3/13/23. 2. Resident 134 received Potassium Chloride ER ([ER-Extended Release] a medicine used to prevent or treat low potassium levels in the body) for over one year without adequate indication for its use. 3. Resident 134 chewed and swallowed Potassium Chloride ER with less than a glass of water. 4. Resident's 134's heart rate was not assessed before administering Lisinopril (a medication to treat high blood pressure and heart failure) based on physician's order to hold for Systolic Blood Pressure (SBP, measures the pressure of your blood in your arteries [tube like structure responsible for transporting blood]) less than (<) 110 milliliters per mercury (mmHg, unit of measurement) and heart rate (HR) < 60 beats per minute (bpm, unit of measurement). 5. Resident 133 received expired insulin medication, Lantus (lowers blood sugar), for 26 days past the expiration date. 6. Resident 7 received expired medication, Humulin R (lowers blood sugar), for 6 days past the expiration date. 7. Resident 9 received expired medication, Tylenol with Codeine #3 (controlled pain medication), for 6 doses past the expiration date. 8. Facility failed to refrigerate Lorazepam (anti-anxiety medication. Anxiety is a feeling of fear, dread and uneasiness) for 16 days in accordance with manufacturer's specifications for Resident 68. 9. Facility failed to ensure to administer Gabapentin (a medicine used to treat partial seizures, nerve pain from shingles and restless leg syndrome) capsule 200 mg three times a day to Resident 482 in accordance with the physician's order. These deficient practices increased the risk of Residents 174, 134, 133, 7, 9, and 68 to experienced serious medical complications such as restlessness, severe weakness, severe pain, high blood sugar, high blood pressure, stroke (occurs when something blocks blood supply to part of the brain or when a blood vessel in the brain bursts), chest pain, cardiac (heart) arrest, hospitalization , and or death. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 3/15/2023 at 5:45 PM, the Department called an Immediate Jeopardy (IJ), a situation in which the facility's noncompliance with one or more requirements of participation had caused, or is likely to cause, serious injury, harm, impairment, or death to a resident, in the presence of the Administrator and Director of Nursing (DON) due to facility's failure to ensure Residents 174, 134, 133, 7, 9, and 68 were free from significant medication errors during medication administration observation. On 3/16/2023, at 7:45 PM, the Administrator and DON provided an acceptable IJ removal plan that included the following: 1. Nurse Practitioner was informed by a licensed nurse regarding non-administration of Losartan medication, advised resident and responsible party to contact Primary Physician. 2. Potassium chloride was discontinued on 3/13/2023 and completed a STAT (immediately) potassium (a mineral) level with normal level result. 3. In-service was provided by the Director of Nursing related to potassium administration based on manufacturer's specification for Potassium ER, swallow whole do not crush or chewed, do not allow to dissolve in the mouth and must be taken containing 8 ounces (oz, a unit of measurement) of water. 4. In-service was provided by the Director of Nursing related to proper administration of multivitamins by shaking the bottle before administration. 5. Resident 133 expired Lantus was replaced with a new open insulin pen on 3/15/2023. 6. Resident 7 expired Humulin R insulin was replaced with new Insulin vial on 3/15/2023. 7. Residents 9 expired Tylenol with codeine #3 replaced with new Tylenol Codeine #3 on 3/15/2023. 8. Resident 68 lorazepam was replaced with new lorazepam on 3/15/2023. 9. Resident 134 Artificial tears replaced with a new Artificial Tears on 3/13/2023. 10. The facility Medical Director was notified by the Assistant Director of Nursing (ADON) regarding the facility noncompliance of pharmacy services surrounding medication administrations, drug labeling and storage including residents affected. On 3/16/2023 at 8:30 PM, the Department removed the IJ after verifying and confirming onsite that the facility implemented the IJ removal plan in the presence of the Administrator and DON. Findings: 1. A review of Resident 174's Admission Record indicated the facility admitted Resident 174 on 1/21/23, with diagnoses that included end stage renal (kidney) disease (a medical condition in which the kidneys stop working permanently leading to dialysis [a procedure to remove waste product and excess fluid from the blood] or kidney transplant [a surgery done to replace a diseased kidney with a healthy kidney from a donor]), cerebral infarct (lack of adequate blood supply to brain cells), diabetes mellitus (blood sugar problem), and hypertension (high blood pressure). (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of Resident 174's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 1/27/23, indicated Resident 174 had no memory and cognitive (thought process and ability to reason or make decisions) impairment. A review of Resident 174's Order Summary, indicated an active medication order for Losartan Potassium Oral Tablet 50 milligrams (mg, a unit of measurement) give one tablet by mouth one time a day for hypertension, hold for SBP < 110 or HR < 60 with an order date of 1/21/23. A review of Resident 174's Order Summary, indicated an active medication order dated 1/21/23 for Losartan Potassium Oral Tablet 50 mg, give one tablet by mouth one time a day for hypertension, hold for SBP < 110 mmHg or HR < 60 bpm. A review of Resident 174's Medication Administration Record (MAR), dated 1/1/23 to 1/31/23, 2/1/23 to 2/28/23, and 3/1/23 to 3/31/23, indicated there was no Losartan Potassium 50 mg one (1) tablet once daily by mouth listed. During a concurrent interview and record review with Licensed Vocational Nurse (LVN) 7, on 3/13/23, at 11:56 AM, LVN 7 reviewed and verified Resident 174's MAR on 3/13/23. LVN 7 stated there was no Losartan Potassium 50 mg 1 tab once daily by mouth transcribed in the MAR. LVN 7 stated she had never administered Losartan Potassium to Resident 174. During an interview with Registered Nurse (RN) 4, on 3/13/23, at 11:59 AM, RN 4 stated Losartan Potassium 50 mg 1 tablet once daily by mouth was ordered on 1/21/23 and the medication was not transcribed on the MAR from 1/1/23 to 3/31/23. RN 4 stated Losartan Potassium was not administered to Resident 174. RN 4 stated Resident 174 was a dialysis resident and the resident's blood pressure needed to be managed and controlled (by medication). RN 4 stated elevated and uncontrolled blood pressure can lead to heart problems, stroke, and death. During an interview with Resident 174, on 3/13/23, at 2:52 PM, Resident 174 stated he has a history of hypertension. Resident 174 stated he was taking Losartan Potassium for high blood pressure and reported dizziness during wheelchair transfers (to and from the bed). A review of Resident 174 record, titled Weights and Vitals Summary, indicated Resident 174 had the following blood pressure readings: - 1/23/23- 159/67 mmHg - 1/24/23 - 168/50 mmHg - 1/25/23 - 154/80 mmHg - 1/31/23 - 176/57 mmHg - 2/03/23- 160/84 mmHg (8:46 AM) - 2/03/23 - 160/78 mmHg (4:57 PM) - 2/04/23 - 160/80 mmHg (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	- 2/05/23 - 158/89 mmHg - 2/14/23 - 176/74 mmHg - 2/15/23 - 156/60 mmHg - 2/19/23 - 160/66 mmHg (8:06 AM) - 2/19/23 - 152/64 mmHg (12:05 PM) - 2/19/23 - 159/57 mmHg (4:01 PM) - 2/20/23 - 158/89 mmHg - 2/23/23 - 158/80 mmHg - 2/24/23 - 169/67 mmHg - 2/26/23 - 159/89 mmHg (8:16 AM) - 2/26/23 - 158/68 mmHg (5:52 PM) - 2/27/23 - 160/76 mmHg - 3/01/23 - 156/74 mmHg - 3/03/23 - 158/70 mmHg - 3/04/23 - 152/60 mmHg - 3/05/23 - 160/72 mmHg - 3/06/23 - 159/74 mmHg (10:46 AM) - 3/06/23 - 160/62 mmHg (6:10 PM) - 3/08/23 - 168/60 mmHg- - 3/10/23 - 160/72 mmHg - 3/11/23 - 156/68 mmHg (12:13 PM) - 3/11/23 - 160/66 mmHg (4:37 PM) - 3/11/23 - 152/62/mmHg (6:44 PM) (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of Resident 174's Care Plan initiated on 1/21/23 and revised on 1/24/23, indicated Resident exhibits or is at risk for cardiovascular (refers to heart and blood vessel disease) symptoms or complications related to diagnosis of hypertension, bradycardia (low heart rate), hyperlipidemia (high fats in the blood), and cerebrovascular accident (CVA, also known as stroke and complication of high blood pressure). The Care Plan intervention indicated, To administer meds as ordered and assess for effectiveness and side effects and report abnormalities to physician. During an interview with the Registered Nurse Supervisor (RNS) on 3/13/23, at 3:07 PM, the RNS stated the RN or LVN carry out the physician order. The RNS stated, Pharmacy automatically receives medication order once order is entered in PCC (Point Click Care, a software for digital data of residents). During an interview with the DON on 3/13/23, at 3:34 PM, the DON stated Licensed nurse enters physician order in PCC once order is received and confirmed. The pharmacy immediately has access to the new order once it is entered in PCC. The facility should call or fax the pharmacy to confirm if the order was received. 2. A review of Resident 134's Admission Record indicated the facility admitted Resident 134 on 9/1/2021 with diagnoses that included nonrheumatic aortic valve stenosis (narrowing of the aortic valve [part of the heart] opening), mitral valve insufficiency (a heart disease in which the valve between the left heart chambers does not close completely), diabetes mellitus, hypertension and chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should). A review of Resident 134's MDS, dated [DATE], indicated Resident 134 had no memory and cognitive impairment. During a medication pass observation, on 3/13/23, from 9:02 AM to 9:22 AM, with LVN 11, in Nursing Station 2, at Medication Cart (Med Cart 2). LVN 11 prepared and gave one tablet of Potassium Chloride Extended Release (ER), 10 milliequivalents (mEq, unit of measurement) by mouth to Resident 134. During an interview with RN 4, on 3/13/23, at 11:08 AM, and concurrent review of the physician Order Summary Report, dated 12/27/22, 1/23/23, and 3/13/23, indicated Potassium Chloride ER tablet extended release 10 mEq one tablet by mouth, one time a day, as a supplement for Lasix (a medication which increases urine output). RN 4 stated Resident 134 continued to receive Potassium Chloride ER after Lasix was last given and discontinued on 1/17/22. RN 4 stated, Potassium Chloride ER order should have been clarified with the physician when Lasix was discontinued on 1/17/22. The RN 4 stated the purpose of Potassium Chloride ER supplement is to replenish the resident's potassium depleted by Lasix. RN 4 stated if Potassium Chloride ER is continued without Lasix, Resident 134 can have hyperkalemia which can cause symptoms like chest pain, irregular heartbeat, and hospitalization . During an interview with Resident 134, on 3/13/23, at 3:13 PM, Resident 134 stated I felt tingling on my hands for one week when I rub my hands together. During an interview with LVN 11, on 3/13/23, at 3:19 PM, LVN 11 stated if Lasix is prescribed for a resident, it should be supplemented with potassium. LVN 11 stated once Lasix is discontinued, the potassium should be discontinued depending on the resident's potassium level. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview with the DON, on 3/13/23, at 3:34 PM, the DON stated, The pharmacy is informed when a medication is discontinued in PCC (Point Click Care, a software for digital data of residents). The DON stated, Indication for potassium in Order Summary should be updated if potassium is ordered as a supplement for Lasix and should be discontinued after Lasix is discontinued. A review of Resident 134's record, titled Order Summary Report, dated 3/13/23, indicated Potassium Chloride ER Tablet Extended Release 10 mEq was ordered on 9/01/2021, to give one tablet by mouth, one time a day, for supplement of taking Lasix. 3. During the medication pass observation with on 3/13/23, at 9:22 AM, LVN 11 administered Potassium Chloride ER 10 mEq one tablet and Resident 134 bit the tablet, quickly chewed, and swallowed the medication with less than 6-8 ounces of water. During an interview with Resident 134, on 3/13/23, at 9:31 AM, Resident 134 stated she bit the Potassium tablet to little pieces before swallowing it. Resident 134 stated she drank approximately 1 ounce of water with Potassium. During an interview with LVN 11, on 3/13/23 at 9:51 am, LVN 11 stated the plastic cup was a four-ounce cup. LVN 11 stated, Potassium Chloride tablet should be taken with 6-8 ounces of water. LVN 11 stated Potassium Chloride tablet should not be cut, crushed, or chewed because it is enteric coated (medication with special mechanism to protect the stomach from irritation when swallowed) and can cause stomach irritation. During an interview with RN 4, on 3/13/23, at 11:08 AM, RN 4 stated, Potassium Chloride tablet should be given as a whole tablet and should not be crushed or cut because it is an extended-release tablet. The RN 4 stated Potassium Chloride tablet should be given with a whole glass of water. A review of the facility's Policy and Procedure titled, Potassium Chloride (All Populations Monograph), dated 3/16/23, indicated to administer all oral dosage forms with a full glass of water (or other liquid) with or immediately after food. The policy indicated to swallow whole; do not crush or chew; do not allow to dissolve in mouth. 4. During a medication pass observation, on 3/13/23, from 9:02 AM to 9:22 AM, with LVN 11, in Nursing Station 2, at Med Cart 2, LVN 11 prepared one tablet of Lisinopril 2.5 mg and LVN 11 did not assess Resident 134's heart rate before administering the Lisinopril. During an interview with LVN 11, on 3/13/23, at 10:02 AM, LVN 11 stated that Resident 134's heart rate was not checked to see if it is below 60 beats per minute prior to administering Lisinopril. LVN 11 stated, I messed up on the heart rate. LVN 11 stated that one of the consequences of not checking the heart rate before administering Lisinopril can lower the resident's heart rate even more. LVN 11 stated it is important to check the resident's blood pressure and heart rate parameters as ordered by the physician. A review of Resident 134's record, titled Order Summary Report, dated 3/13/23, indicated Lisinopril tablet 2.5 mg, ordered on 9/1/2021, give 1 tablet by mouth, one time a day for hypertension, hold for SBP <110 and HR<60. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	5. A review of Resident 133's Admission Record, indicated the facility admitted the resident on 5/31/22 for osteomyelitis (bone infection), respiratory (lungs) failure, type 2 diabetes (a condition caused by high blood sugar levels that can lead to blindness, improper wound healing, and increases risk for heart attack and stroke), and pressure ulcer (injury to tissue and skin resulting from pressure on the skin). A review of Resident 133's MDS, Section C (Cognitive or mental status), dated 12/8/22, indicated Resident 133 had severely impaired cognition. During a medication pass observation, on 3/14/23, at 1:10 PM, found an opened vial of Lantus with the name of Resident 133 and dated 1/19/23, past 28 days from open date. During an interview with LVN 6, on 3/14/23, at 1:14 PM, LVN 6 stated The Lantus was expired based on the open date and should not be in the medication cart. LVN 6 stated the medication was given to the resident daily since 1/19/23 and needed to be unexpired because residents could become hyperglycemic (increased blood sugar) from using expired Lantus. LVN 6 stated expired Lantus might not provide full strength of the medication and will not lower the resident's blood sugar During an interview with LVN 5, on 3/16/23, at 8:42 AM, LVN 5 stated Nurses must check expiration dates when administering medication because expired medications will not be as effective. LVN 5 stated Lantus expires twenty-eight days after it is opened. During an interview with RN 2, on 3/16/23 at 8:25 AM, RN 2 stated expired Lantus might not be as effective and might cause an adverse consequence or hyperglycemia. During an interview with the Director of Nursing (DON), on 3/16/23 at 8:55 AM, the DON stated, Expired medications should not be given, and staff are trained on checking the medication expiration date along with the seven rights of administration and should be checking the expiration dates when administering medications. During an interview with the Pharmacist, on 3/16/23 at 11:13 AM, the Pharmacist stated, Expired medications should not be given to residents because the efficacy may be lowered. Pharmacist stated Lantus expires twenty-eight days after the vial is opened. Pharmacist also stated a random spot check is done on the medication carts during the monthly pharmacist visit and it is possible to miss an expired medication. A review of Resident 133 record, titled Medication Administration Record (MAR), indicated Resident 133 received twenty-six expired doses of Lantus every day at 9 PM from 2/16/23 to 3/13/23. A review of Resident 133's Progress Notes, dated 3/15/23, indicated Resident 133 received expired Lantus from a vial that had been opened for more than twenty-eight days. A review of the facility policy, titled Administering Medications, with revised date 4/2019, indicated the expiration date or beyond use date on the medication label is checked during medication administration and if using a multidose container, the date of opening is recorded on the container. 46779 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rio Hondo Subacute & Nursing Center	273 E Beverly Boulevard Montebello, CA 90640

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	6. A review of Resident 7's Admission Record indicated the facility admitted Resident 7 on 2/7/23 with diagnoses that included type II diabetes mellitus and bipolar disorder (a mental health condition that causes extreme mood swings that include emotional highs and lows). A review of Resident 7's MDS, dated [DATE], indicated Resident 7 had severely impaired memory and cognition. Resident 7 required limited assistance (resident highly involved in activity, staff provide guided maneuvering of limbs or other non-weight-bearing assistance) with bed mobility and eating, and extensive assistance (resident involved in activity, staff provide weight-bearing support) with transfer, dressing, toilet use and personal hygiene. A review of Resident 7's Order Summary Report, dated 3/23, the Order Summary Report indicated, Resident 7 to receive Insulin Regular (a short-acting insulin) as per sliding scale (a sliding scale varies the dose of insulin based on blood sugar level) starting on 2/7/23. A review of Resident 7's Medication Administration Record (MAR), dated 3/23, the MAR indicated, Resident 7 received Insulin Regular from 3/1/23 to 3/14/23. During a medication storage observation, on 3/14/23, at 4:20 PM, found a medication bottle labeled with Humulin R and Resident 7's name in the top right drawer in the medication cart 2 of facility station 1. The 2/8 was written on the opened vial of Humulin R for date opened. During an interview with LVN 10, on 3/14/23, at 4:30 PM, LVN 10 stated, The opening date for this opened vial of Humulin R was 2/8/23 and it would expire after 28 days it was opened. LVN 10 stated the expired vial of Humulin R should have been removed from the medication cart. LVN 10 stated (Resident 7) continued to receive the expired Humulin R after the expiration date. LVN 10 stated the expired medication would lose its effectiveness and could lead to hyperglycemia and other negative reactions on Resident 7. During an interview with the DON, on 3/16/23, at 8:55 AM, the DON stated the expired medication should not be given to the residents and staff should check the medication expiration date along with the seven rights of administration when administering medications. During an interview with LVN 1, on 3/16/23, at 10:39 AM, LVN 1 stated the nurse would label the opening date on the insulin bottle and the insulin would expire after 28 days it was opened. LVN 1 stated The expired insulin was not effective and could develop allergic reaction or hyperglycemia. During an interview with Director of Staff Development (DSD), on 3/16/23, at 10:46 AM, the DSD stated, Insulin was good for 28 days after opening and the nurse should label the opening date on the bottle and possible reaction to a resident if receiving expired insulin could be hyperglycemia. A review of the facility policy, Administering Medications, dated 4/2019, the policy indicated the expiration date or beyond use date on the medication label is checked during medication administration and if using a multidose container, the date of opening is recorded on the container. 7. A review of Resident 9's admission record indicated the facility admitted the resident on 7/14/22 for diagnoses including congestive heart failure (heart does not pump blood as well as it should to the rest of the body), hypertension (high blood pressure), kidney disease, dementia (condition involving impairment of brain functions like memory), and chronic pain syndrome. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of Resident 9's Minimum Data Set Assessment Section C, dated 1/27/23, indicated Resident 9 had severely impaired cognition. During a concurrent medication storage observation and interview with LVN 7, on 3/14/23, at 4:15 PM, at Med Cart 2 on Unit 2, Resident 9's bubble pack (supply of medications with individually sealed compartments) of Tylenol with Codeine #3 (a habit-forming pain medication) had an expiration date of 3/5/23 printed on the bubble pack of the medication. LVN 7 stated Resident 9 had an order for Tylenol with Codeine #3 to be taken as needed for moderate pain and had been receiving expired medication since 3/5/23. LVN 7 stated the resident received six expired doses of Tylenol with Codeine #3 with the last dose being administered on 3/14/23. During an interview with the DON, on 3/16/23 at 8:55 AM, the DON stated expired medications should not be given and staff are trained on checking the medication expiration date along with the seven rights of administration and should be checking the expiration dates when administering medications. The DON stated checking for expired controlled medications are done during the DON's daily rounds on the units. The DON stated the expectation is for nurses to bring expired controlled medications that are no longer in use to the DON office immediately or before the end of the day. During an interview with the Pharmacist, on 3/16/23 at 11:13 AM, the Pharmacist stated expired medications should not be given to residents because the efficacy may be lowered. Pharmacist also stated a random spot check is done on the medication carts during the monthly pharmacist visit. 8. A review of Resident 68's Admission Record indicated the facility admitted Resident 68 on 1/26/22, with diagnoses that included cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area, also known as stroke) and bipolar disorder (a mental health condition that causes extreme mood swings that include emotional highs and lows). During a medication storage observation, on 3/14/23, at 3:40 PM, found a medicine paper package labeled with Lorazepam Oral concentrate and labeled with Resident 68's name was stored in the narcotics (a drug or substance that affects mood and behavior) drawer of the medication cart 1 of facility station 1 at room temperature. The Lorazepam Oral Concentrate package indicated Discard 90 days after opening, and Store at cold temperature, refrigerate at 2-degree to 8-degree Celsius, No open date recorded or written on Lorazepam paper package. The bottle of Lorazepam was filled on 2/24/23. During an interview with LVN 10, on 3/14/23, at 3:55 PM, LVN 10 stated there were no open dates recorded on either the Lorazepam bottle or the paper package. LVN 10 stated this bottle of Lorazepam Oral Concentrate had been stored at room temperature in the medication cart 1 consistently and did not know when this bottle of Lorazepam was opened since there was no opening date on the bottle. LVN 10 stated she did not know Lorazepam Oral Concentrate needed to be refrigerated after opening. A review of Resident 68's Order Summary Reports, dated 2/23 and 3/23, indicated, Resident 68 to receive Lorazepam Oral Concentrate (a medication is used to treat anxiety) 1 mg two times a day for anxiety manifested by inconsolable yelling and screaming, starting on 12/24/22. A review of Resident 68's Medication Administration Record (MAR), dated 3/23, indicated, Resident 68 received Lorazepam Oral Concentrate 1 mg two times a day from 2/23 to 3/14/23. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of Lorazepam Oral Concentrate package box and paper insert, indicated, Manufacture's Specifications for Lorazepam Oral Concentrate should be refrigerated at 2-degree Celsius to 8-degree Celsius and discard opened bottle after 90 days. During a concurrent record review and interview with LVN 10, on 3/14/23, at 4:00 PM, Resident 68's Narcotic (a drug or other substance that affects mood or behavior) Count Sheet, dated 3/14/23, indicated the current bottle of Lorazepam Oral Concentrate that was stored at room temperature in the medication cart 1 station 1 was opened on 2/27/23. LVN 10 stated she had Resident 68 for multiple days and had been administered Lorazepam from this bottle of Lorazepam Oral Concentrate that was stored at room temperature and would lose its effectiveness if not stored in the refrigerator and would not have desired effect on Resident 68 to control his anxiety and agitation. During an interview with LVN 1, on 3/16/23, at 10:39 AM, LVN 1 stated Lorazepam liquid should be kept in the refrigerator and locked. LVN 1 stated the medication that required to be refrigerated would not be effective if it was not put in the refrigerator. LVN 1 stated the medication should be labeled with the opening date on the bottle when it was opened. During an interview with the Director of Staff Development (DSD), on 3/16/23, at 10:49 AM, the DSD stated, If a medication was required to be refrigerated but was stored at room temperature, the potency of the medication would be affected and should not be given to residents. The DSD stated medication should be labeled with opening date on the bottle when it was opened. 42878 9. A review of Resident 482's Admission Record indicated resident was originally admitted to the facility on [DATE] and then readmitted on [DATE] with diagnosis that included, metabolic encephalopathy (a condition in which brain function is disturbed either temporarily or permanently), type 1 diabetes mellitus (a chronic condition in which the pancreas produces little or no insulin with diabetic polyneuropathy(a condition in which a person's peripheral nerves are damaged) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily functioning). A review of Resident 482's History and Physical (H&P) dated 3/09/23 indicated Resident 482 has fluctuating capacity to understand and make decisions. A review of the Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 3/01/23, indicated Resident 482 requires two- person assist with total dependence (full staff performance every time) for bed mobility. The MDS indicated Resident 482 requires one- person total dependance for dressing, toilet use, personal hygiene. A review of Resident 482's Physician order summary for the month of March 2023, indicated, on 9/22/22, resident's physician ordered for Gabapentin capsule 100 milligrams (mg - a unit of measure for mass), give 2 capsules by mouth three times a day for neuropathic pain. The order did not indicate it was discontinued from 3/7/23 to 3/16/23. A review of Resident 482's Physician order summary for the month of March 2023, indicated on 3/7/23, resident's physician ordered for Gabapentin capsule 200 milligrams orally three times a day for neuropathy. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review Resident 482's Medication Administration Record (MAR) for the month of order summary, indicated an order for: a. Gabapentin capsule 100 mg, give 2 capsules by mouth three times a day for neuropathic pain and it was administered (MAR with a check mark) to Resident 482 from 3/7/23 to 3/12/23. b. Gabapentin capsule give 200 mg orally three times a day for neuropathy and it was administered (MAR with a check mark) to Resident 482 from 3/7/23 to 3/17/23. During an interview and concurrent record review on 3/16/23 at 4:16 PM with LVN 13, LVN 13 confirmed, a check mark in the MAR indicated the medication had been administered. LVN 13 confirmed she had administered Gabapentin 100 mg, 2 capsules to Resident 482 on 03//23 at 5:00 PM and she administered Gabapentin capsule 200 mg to Resident 482 on 03//23 at 9:00 PM. LVN 13 stated she did not realize that the Gabapentin was a duplicate order. LVN 13 stated Gabapentin 100 mg ordered should have been discontinued when Resident 482 was readmitted on [DATE] since there was a new order of Gabapentin 200 mg three times days on March 7. LVN 13 stated all nurses should always check medications including the physician's order before administering to prevent Resident's from being over medicated. During an interview and concurrent record review with the Director of Nursing (DON) on 3/16/23 at 5:08 PM, the DON stated admitting nurses should always review all the resident's medication and discontinue any previous orders and enter all new set of orders when a resident is readmitted to the facility. The DON stated it was important to make sure to check the physician orders to ensure there was no duplicate order of the same medicine with the same dose and to make sure the facility is giving the correct dose to the resident in accordance with the physician's order. A review of the facility's policy and procedure titled, Administering Medications, revised April 2019, indicated Policy Statement: Medication are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation: . 4. Medications are administered in accordance with prescriber orders including any required timeframe . 47331

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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. 46919 Based on observation, interview, and record review, the facility failed to provide safe provision of pharmaceutical services by: 1. Failure to label the medication Benazepril HCl (a medication to treat high blood pressure) with a resident's name, administration dose, route, frequency to indicate when the medication should be administered. 2. Failure to store Lorazepam (anti-anxiety medication) in refrigerator without open date. 3. Failure to maintain medication room refrigerator with residents' vaccines (a preparation used to stimulate the body's immunity to disease) stored inside. These deficient practices had the potential to cause medication errors by possibly administering the medication to the wrong resident and lead to unsafe nursing practice. Findings: 1. During an observation of Medication Cart (MedCart 1), in Station 4, on 3/15/23, at 7:10 PM, four tablets of Benazepril HCl 5 mg, with an expiration of 11/23, were found with the bulk/over-the-counter medications in MedCart 1. The four tablets were not labeled with the resident's name, administration dose, route, frequency, and ordering physician. During an interview with Licensed Vocational Nurse (LVN 13), on 3/15/23, at 7:12 PM, LVN 13 confirmed the four unlabeled Benazepril HCL medications were placed with the over-the-counter medications. LVN 13 stated she did not know why Benazepril was in Medcart 1 and which resident the medication belonged to. LVN 13 stated the resident's name should be on the bubble pack (packaging in which medications are organized and sealed between a backing and clear plastic cover). LVN 13 stated Benazepril HCl is a medication used to treat high blood pressure and should not be mixed with bulk/over-the-counter medications. LVN 13 confirmed that unlabeled medications should be placed in a locked cabinet in the medication storage room. On 3/15/23 at 7:20 PM, LVN 13 observed placing the four unlabeled tablets of Benazepril HCl 5 mg in a locked cabinet inside the medication storage room located in Nursing Station 4. On 3/15/23, at 7:32 PM, LVN 13 informed Assistant Director of Nursing (ADON) in Station 4 that four tablets of unlabeled Benazepril were found in Medcart 1. ADON stated she did not know who the unlabeled medications belonged to. ADON stated that it was a medication error if an unlabeled medication is administered to a resident. ADON stated a resident's blood pressure could decrease if the medication was given incorrectly. ADON stated Benazepril should have been removed from Medcart 1 and placed in the incinerator. AFON confirmed unlabeled medications should not be placed in the medcarts. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Contracted Omnicare Pharmacist (Pharmacist), on 3/16/23, at 11:14 AM, the Pharmacist stated all medications brought from home need to have a physician's order and be verified and labeled by the pharmacy. The Pharmacist stated that Benazepril was a medication for high blood pressure and should have come with a pharmacy label and not as a unit dose. Pharmacist stated Benazepril should not have been placed in MedCart 1 without a pharmacy label. Pharmacist confirmed that all medications in the MedCart should be labeled. Pharmacist confirmed it was a medication error if unlabeled Benazepril was given to a resident. Pharmacist stated giving Benazepril incorrectly can cause dizziness, drowsiness, falls, hospitalization , and low blood pressure. A record review of the facility's Policy and Procedure titled, Storage of Medications, revised on November 2020, indicated Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. A record review of the facility's Policy and Procedure titled, Pharmacy Services Overview, revised April 2019, indicated Medications are received, labeled, stored, administered and disposed of according to all applicable state and federal laws and consistent with standards of practice. 2. A review of Resident 68's Admission Record indicated the facility admitted Resident 68 on 1/26/22 with diagnoses that included cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area, also known as stroke) and bipolar disorder (a mental health condition that causes extreme mood swings that include emotional highs and lows). A review of Resident 68's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 2/9/23, indicated Resident 68 had severely impaired memory and cognition (ability to think and reason). Resident 68 was total dependent (full staff performance every time during entire 7-day period) on transfer and required extensive assistance (resident involved in activity, staff provide weight-bearing support) with bed mobility, dressing, eating, toilet use and personal hygiene. During a review of Resident 68's Order Summary Reports, dated 2/23 and 3/23, indicated, Resident 68 to receive Lorazepam Oral Concentrate (a medication is used to treat anxiety) one milligram (mg) two times a day for anxiety manifested by inconsolable yelling and screaming, starting on 12/24/23. During a review of Resident 68's Medication Administration Record (MAR), dated 3/23, the MAR indicated, Resident 7 received insulin regular from 3/8/23 to 3/14/23. During a concurrent observation and interview on 3/14/23, at 3:55 PM, with LVN 10, a medicine paper package labeled with Lorazepam Oral concentrate and Resident 68's name was stored in the narcotics drawer of the Medication cart 1 station 1 at room temperature. Discard 90 days after opening and Store at cold temperature, refrigerate at 2-degree to 8-degree Celsius, were printed on this paper package of Lorazepam. There was no opening date recorded on this Lorazepam paper package. A bottle of Lorazepam Oral Concentrate two mg per milliliter (ml) labeled with Resident 68's name was inside of the Lorazepam paper package. There was no opening date recorded on the Lorazepam bottle. The bottle of Lorazepam was filled on 2/24/23. LVN 10 stated there were no opening date recorded on either the Lorazepam bottle or the paper package. LVN 10 stated this bottle of Lorazepam Oral Concentrate had been stored at room temperature in the medication cart 1 consistently and she did not know when this bottle of Lorazepam was opened since there was no opening date on the bottle. LVN 10 further stated she did not know Lorazepam Oral Concentrate needed to be refrigerated after opening. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/14/23, at 3:57 PM, with LVN 10, Manufacturer's Specifications on the package box and insert of Lorazepam Oral Concentrate, indicated Lorazepam Oral Concentrate should be refrigerated at 2-degree Celsius to 8-degree Celsius and discard opened bottle after 90 days. During a concurrent interview and record review on 3/14/23, at 4:00 PM, with LVN 10, Resident 68's Narcotic (a drug or other substance that affects mood or behavior) Count Sheet, dated 3/14/23, indicated the current bottle of Lorazepam Oral Concentrate that was stored at room temperature in the medication cart 1 station 1 was opened on 2/27/23. LVN 10 stated she had Resident 68 for multiple days and had been administered Lorazepam from this bottle of Lorazepam Oral Concentrate that was stored at room temperature to Resident 68 since the opening date of 2/27/23 for anxiety and agitation. LVN 10 stated Lorazepam would lose its effectiveness if not stored in the refrigerator and would not have desired effect on Resident 68 to control his anxiety and agitation. During an interview on 3/16/23, at 10:39 AM, with LVN 1, LVN 1 stated Lorazepam Liquid should be kept in the refrigerator and locked. LVN 1 further stated the medication that required to be refrigerated would not be effective if it was not put in the refrigerator. LVN stated the medication should be labeled with the opening date on the bottle when it was opened. During an interview on 3/16/23, at 10:49 AM, with Director of Staff Development (DSD), DSD stated if a medication was required to be refrigerated but was stored at room temperature, the potency of the medication would be affected and should not be given to residents. DSD stated medication should be labeled with opening date on the bottle when it was opened. 46779 3. During a concurrent observation and interview on 3/15/23, at 9:00 AM, with LVN 4, in the medication room station 4, LVN 4 stated the single door mini refrigerator with a sign VACCINES ONLY posted on the refrigerator door was for vaccines only. There was a freezer compartment inside of the single door mini refrigerator. When LVN opened the vaccine refrigerator, water droplets were forming at the bottom of the freezer compartment. Some water droplets were dripping down to the first shelf, second shelf and the bottom shelf of the refrigerator. Several Influenza vaccine boxes on the first shelf were wet with yellow water marks on the boxes. The Influenza vaccine boxes on the second shelf were moist to touch. The thermometer inside the refrigerator indicated 43 degrees Fahrenheit. There was no ice formed in the freezer compartment and the tray below the freezer compartment was full of water. LVN 4 stated there were 32 boxes of Influenza vaccines with 10 vials per box in the refrigerator. LVN 4 stated she did not know for how long the refrigerator had been malfunction. LVN 4 stated the boxes of the vaccines should not be damaged and these damaged vaccines could not be administered to the residents. During a concurrent observation and interview on 3/15/23, at 9:16 AM, with housekeeping, housekeeping stated the refrigerator and the floor in the medication room station 4 were wet and she was not aware the refrigerator was not working correctly. During a concurrent observation and interview on 3/15/23, at 9:19 AM, with RN 5, in the medication room station 4, RN 5 stated the vaccine refrigerator was wet and she did not know the refrigerator was not working. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/15/23, at 9:40 AM, with LVN 4, LVN 4 stated the vaccine refrigerator should be kept between 36-degree Fahrenheit and 46-degree Fahrenheit per facility's Temperature Log For Medication/Vaccine Refrigerators. LVN 4 stated the leaking water onto the boxes of the vaccines could damage the medications and most likely the refrigerator temperature was out of range. LVN further stated if the Influenza vaccines were not kept at right temperature, it would loss its effectiveness against influenza virus and cause the resident to contract flu. During a concurrent observation and interview on 3/15/23, at 9:27 AM, with the Director of Maintenance (DM), DM stated the ice in the freezer compartment inside of the vaccine refrigerator melted, causing water dripping down to the lower shelves. DM stated he was not notified the malfunction of the vaccine refrigerator until today. DM stated the causes of ice melting in the freezer could be the power was off, the refrigerator was off, and the refrigerator on the defrost mode. During an interview on 3/15/23, at 10:04 AM, with RN 5, RN 5 stated the vaccines in this refrigerator might not be stored at the right temperature. RN 5 stated if the vaccines that were stored at out-of-range temperature and was damaged might lead to adverse reactions, like allergies and fever, the residents not receiving the vaccines in full dose, and the vaccines losing their effectiveness. During an interview on 3/16/23, at 6:50 PM, with Infection Preventionist (IP), IP stated she all the Influenza vaccines inside of the vaccine refrigerator in the medication room station 4 might not be stored at the correct temperature between 36-degree Fahrenheit and 46-degree Fahrenheit per manufacture's specification due to the malfunction of the refrigerator since the refrigerator was not working properly. IP stated all the Influenza vaccines boxes that were wet and damaged in that refrigerator were discarded due to improper storage. IP further stated improperly stored Influenza vaccines would lose it potency and effectiveness against flu virus and should not be given to the residents. A review of the facility's policy and procedure titled, Storage of Medications, dated November 2020, indicated, drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. 47331

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Rio Hondo Subacute & Nursing Center	273 E Beverly Boulevard Montebello, CA 90640

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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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42334 Based on interview and record review, the facility failed to follow physician's laboratory (where blood, urine and other body samples are processed and evaluated) orders for one (Resident 10) of two sampled residents by not obtaining a urine culture that was ordered for Resident 10 and sending it to the laboratory to be tested . This deficient practice had the potential to negatively affect Resident 10's health by putting the resident at risk for having an untreated infection. Findings: A review of Resident 10's Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of, but not limited to, end stage renal disease (the final stage of kidney failure), type 2 diabetes (a chronic disease that affects how the body processes sugar in the blood), heart failure (a chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs), and Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors). A review of Resident 10's comprehensive admission Minimum Data Set (MDS - a standardized assessment and screening tool) dated 2/1/23, indicated the resident had impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making with difficulties in memory and making needs known. The MDS indicated the resident was extensively dependent to totally dependent on staff for activities of daily living (ADLs - term used in healthcare to refer to daily self-care activities). A review of Resident 10's physicians order dated 3/10/23 at 5:23 PM indicated that MD1, wrote the following orders Urine Culture. Noted and carried out. During an interview and concurrent record review of Resident 10's medical chart from 3/10/23 to 3/16/23, on 3/16/23 at 11:19 AM, Registered Nurse 4 (RN 4) stated, the urine cultures that were ordered by Resident 10's physician on 3/10/23 (6 days ago) were never done. RN4 stated he called the laboratory to verify that the urine samples for the urine culture test were never sent. RN4 stated, the risk to the resident is that the resident could have a urinary tract infection (UTI- An infection in any part of the urinary system, the kidneys, bladder, or urethra.) and it would be missed and will not be treated which may lead to severe illness. During an interview on 3/16/23 at 11:21 AM, Director of Nursing (DON) stated, not sending the urine sample to the laboratory was not following the doctor's order, and it should have been implemented. DON stated it puts the resident at risk for untreated infection. A review of facility's policy and procedure titled, Physician's Orders, dated 3/22/22, indicated, the Licensed Nurse receiving the order will be responsible for documenting and implementing the order.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47348 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: 1.Three tuna salad sandwiches and three ham sandwiches stored in the walk-in in refrigerator with a use by date of [DATE] and 1 medium plastic container of chicken base stored in the walk-in refrigerator with use by date of [DATE] exceeding storage periods for ready to eat food. One open package of cooked ham in plastic storage bag stored in the refrigerator with date ,d+[DATE] exceeding storage periods for ready to ready to eat food. 2. One Dietary Aide staff (DA 1) working in the dish machine area did not wash hands when removing the clean and sanitized dishes from the dish machine. This failure had the potential to cross contaminate dishes and cause food borne illness to resident who eat form the facility's kitchen. 3. The can opener blade was dented and nicked with the potential to harbor harmful bacteria that were not easily cleanable. These deficiencies had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness in 133 out of 163 residents who received food from the kitchen. Findings: 1. During a concurrent observation and interview with Registered Dietitian (RD) on 8:05 AM, there were three tuna salad sandwiches and three ham sandwiches with use by date of [DATE] stored in the walk-in refrigerator. RD stated the sandwiches were left over from residents who didn't want it during the weekend. RD stated that sandwiches from the previous day should be discarded. RD removed the sandwiches from the cooler. During the same observation and interview, there was cooked ham stored in a plastic storage bag with dates ,d+[DATE] to ,d+[DATE] and one medium container of chicken base dated [DATE] to [DATE]. RD stated frozen fully cooked ham was stored for 1 week in the refrigerator. RD verified that cooked ham did not have the correct label and stated it should be dated ,d+[DATE] to ,d+[DATE]. RD said that the chicken base was expired and should not still be in the refrigerator. RD removed the chicken base container from refrigerator. A review of facility's policy, titled Food Storage: Cold Foods policy No.019 (revised ,d+[DATE]) indicated, All Time/Temperature Control for Safety (TCS) foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA Food Code. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the 2022 U.S. Food and Drug Administration Food Code, code: ,d+[DATE].17 titled Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking, indicated, refrigerated, ready-to-eat, time/ Temperature Control for Safety Food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. 2.During an observation in the dish machine area on [DATE] at 8:40 AM, Dietary Aide (DA1) rinsed the soiled dished and loaded the dirty dishes into the dishwashing machine. When the dish machine stopped DA1 removed the clean dishes onto the drying tray without washing hands. During a concurrent observation and interview DA1 stated that she forgot to wash hands before handling the clean dishes. DA1 stated it was important to wash hands when touching clean dishes, DA1 stated the dishes were clean and sanitized, not washing hands can contaminate clean dishes. DA1 stated the hand washing sink was far from the dishwashing area and it is faster to dip hands in sanitizer bucket containing sanitizing solution. During the same observation and interview Dietary Supervisor (DS) stated that staff should wash their hands using soap and water at the hand washing station. DS stated that dipping hands in the sanitizing solution was not the facility policy A review of facility policy titled Ware washing policy No.022 (revised [DATE]) indicated, Dining Services staff will be knowledgeable in the proper technique for processing dirty dishware through the dish machine, and proper handling of sanitized dishware. A review of the 2022 U.S. Food and Drug Administration Food Code, code: ,d+[DATE].12 titled Cleaning Procedure, indicated, Food employees shall clean their hands and exposed portions of their arms for at least 20 seconds, using a cleaning compound in a handwashing sink. A review of the 2022 U.S. Food and Drug Administration Food Code, Code: ,d+[DATE].14 titled When to wash, indicated, Food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single service and single use articles. 3. During an observation in the kitchen on [DATE] at 9:05 AM, one can opener blade noted to be worn and nicked. The blade was not smooth to the touch due to the dents on the surface of the blade. During the same observation, RD and DS examined the blade and verified there were two dents on the blade. DS stated the can opener is cleaned every day and the blade will be replaced. A review of the 2022 U.S. Food and Drug Administration Food Code, Code: ,d+[DATE].11 titled Food-Contact Surfaces, indicated, The purpose of the requirements for multiuse food-contact surfaces is to ensure that such surfaces are capable of being easily cleaned and accessible for cleaning .Surfaces which have imperfections such as cracks, chips, or pits allow microorganisms to attach and form biofilms. Once established, these biofilms can release pathogens to food.

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 47348 Based on observation, interview, and record review, the facility failed to ensure the trash stored in the dumpster area was maintained in a sanitary manner. Two out of five garbage dumpsters were overfilled and uncovered, with debris scattered on the dumpster grounds. This deficient practice had the potential for harborage of pests and vermin, which may be attracted into the facility. Findings: During an observation on 3/13/23 at 9:15 AM, two out of five garbage dumpsters outside in the parking lot were overfilled. Both dumpster lids were left open and unable to close tightly due to overfilling trash. There were trash and debris on the ground around the dumpsters. During an interview with the Director of Maintenance (DM) on 3/13/23 at 10:30 AM, DM stated that the dumpster truck comes every day except for Sundays, and that housekeeping oversaw cleaning the grounds. During an interview with the Housekeeping Supervisor (HS) on 3/13/23 at 10:41 AM, the HS stated the dumpster grounds were cleaned every day, but they did not clean the previous day. HS stated that the grounds needed to be maintained clean to prevent pests and for infection control, because this area has lots of pest problems. A review of facility's undated policy and procedure titled Dispose of Garbage and Refuse, indicated The Dining Services Director coordinates with the Director of Maintenance to ensure that the area surrounding the exterior dumpster area is maintained in a manner free of rubbish or other debris. According to the 2017 U.S. Food and Drug Administration Food Code, proper storage and disposal of garbage and refuse are necessary to minimize the development of odors, prevent such waste from becoming an attractant and harborage or breeding place for insects and rodents, and prevent the soiling of food preparation and food service areas. Improperly handled garbage creates nuisance conditions, makes housekeeping difficult, and may be a possible source of contamination of food, equipment, and utensils. In addition, storage areas must be large enough to accommodate all the containers necessitated by the operation to prevent scattering of the garbage and refuse. All containers must be maintained in good repair and cleaned as necessary to store garbage under sanitary conditions as well as to prevent the breeding of flies. https://www.fda.gov/media/110822/download (p. 172).

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on interview and record review, the facility failed to maintain accurate clinical records in accordance with accepted professional standards by failing to document the amount of food taken by two of 40 sampled residents (Residents 177 and 46). This deficient practice placed the residents at risk for not receiving the proper intervention and appropriate provision to prevent weight loss. Findings: 1.A record review of Resident 177's Admission Record indicated Resident 177 was initially admitted , on 2/01/23 with diagnoses including seizures (a temporary disturbance in the electrical activity in the brain), reduced mobility, muscle weakness, and diabetes mellitus (a chronic condition that affects the way the body processes blood sugar). A record review of Resident 177's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 2/06/23, indicated Resident 177 had severely impaired condition and required extensive assistance (resident involved in activity, staff provided weight-bearing support) with one-person assist with bed mobility, eating, and personal hygiene. Resident 177 required total dependence (full staff performance) with one to two-persons assist with dressing and toileting. A record review of Resident 177's Care Plan indicated Resident 177 was at nutritional risk with potential for unstable po (oral) intake related to psychiatric condition; increased protein and calorie requirement for skin wound care and infection; unstable carbohydrate intake with elevated BS (initiated on 2/3/23 and revised on 3/14/23). The Care Plan intervention indicated to monitor intake at all meals and alert dietician and physician to any decline in intake. A record review of Resident 177's Care Plan (initiated on 2/09/23) indicated Resident 177 was at risk for oral health or dental care problems as evidenced by edentulous (lacking teeth). The Care Plan intervention indicated to monitor changes in nutrition/hydration status (changes in intake, ability to feed self, unplanned weight loss/gain, abnormal labs) and notify physician/food and nutrition as indicated. During an interview with Licensed Vocational Nurse 4 (LVN 4), on 3/15/23 at 3:00 PM, Licensed Vocational Nurse (LVN 4) stated that all food intakes should be documented either in the resident's ADL (Activities of Daily Living) chart or in the electronic medical record. LVN stated it was important for meal intake to be documented to understand why the resident was losing weight and to be able to provide the right intervention. During a concurrent interview and record review with Certified Nursing Assistant 3 (CNA 5), on 3/16/23 at 1:40 PM, of the Documentation Survey Report v2 and ADL Record for 2/23 and 3/2023, LVN 3 stated not all meal intake was documented for Resident 177. LVN stated it was important for all meals, including snack, to be documented accurately to prevent dehydration, weight loss, and hospitalization . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 3/16/23 at 8:05 p.m., with Director of Staff Development (DSD) of Resident 177's Documentation Survey Report v2 and ADL Record for 2/23 and 3/23, DSD stated Resident 177 had inconsistent meal intake documented by facility staff. DSD stated it was important for facility staff to accurately document the meal intake of residents. DSD stated not documenting resident meal intake could lead to weight loss. DSD stated certified nursing assistants were instructed to document residents meal intake after every meal including snacks. 2.A record review of Resident 46's Admission Record indicated Resident 46 was initially admitted on [DATE] with diagnoses including dysphagia (difficulty or discomfort in swallowing), adult failure to thrive (a syndrome of weight loss, decreased appetite and poor nutrition), history of COVID-19 (a highly contagious respiratory disease caused by the SARS-CoV-2 virus), and COPD (a lung disease characterized by long term poor airflow). A record review of Resident 46's MDS, dated [DATE], indicated Resident 46 had no memory and cognitive (thought process and ability to reason or make decisions) impairment and required supervision with one-person assist with eating and limited assistance (resident highly involved in activity, staff provide guided maneuvering of limbs or other non-weight bearing assistance) with one-person assist with locomotion (the ability to move from one place to another) on/off unit and dressing. Resident 46 required extensive assistance (resident involved with activity, staff provided weight-bearing support) with bed mobility, transfer, toilet use, and personal hygiene. A record review of Resident 46's Care Plan (initiated on 2/10/22 and revised on 3/13/23) indicated Resident 46 at nutritional risk with a potential for unstable po (oral) intake with COPD exacerbation and substance abuse; increased protein and calorie requirement for wound care needs, with history of failure to thrive. Care Plan intervention indicated to offer alternate food choices if less than 50% consumed at mealtime. During a concurrent interview and record review on 3/16/23 at 8:05 PM, with Director of Staff Development (DSD) of Resident 46's Documentation Survey Report v2 and ADL Record for 2/2023 and 3/2023, DSD confirmed not all meals were documented and there are gaps with the documentation. During an interview on 3/16/23 at 8:35 a.m., Registered Dietician (RD) stated nutrition assessment includes talking to the residents to see how much food the residents consumed and reviewing meal intake documentation in EMAR (tasks) and MAR (under ADL). RD stated residents' meal intake should be documented accurately. RD stated if meal intake documentation was inaccurate it was difficult to assess resident's eating pattern and can delay interventions which could lead to weight loss. A record review of the facility's policy and procedure, effective 5/26/21, titled Intake and Output Recording indicated to document intake and output in the resident's clinical record.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42334 Based on record review and interview, the facility failed to ensure that there was coordination of care between the facility and hospice (designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life, rather than cure) for two (Residents 54 and 108) of three sampled residents receiving hospice care services. a. The hospice calendar for Resident 54 expired on [DATE] and a new calendar of visitation was not on the resident medical record. There was also no current documented evidence that the need for hospice was evaluated. The hospice certification was for [DATE]- [DATE]. The last evidence of hospice staff being at the facility was on [DATE], with the last documented evidence of when hospice care was provided by hospice care staff provided was on [DATE]. b. There was no current documented evidence that the need for hospice was evaluated for Resident 108. The hospice certification was for [DATE] to [DATE]. The was no current care plan from the hospice in the resident's clinical record. The last care plan was dated [DATE]. The hospice calendar expired on [DATE]. Resident 108's clinical record indicated no documented evidence of what type of services were provided by visiting hospice personnel from [DATE] to [DATE]. These failures had the potential for the residents not to receive the hospice services necessary to promote comfort and quality of life as well as care during end of life. Findings: 1. A review of Resident 54's Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of, but not limited to, type 2 diabetes (a chronic disease that affects how the body processes sugar in the blood), heart failure (a chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs), and anxiety (when feelings of worry become excessive, all-consuming, and interfere with daily living.) A review of Resident 54's comprehensive admission Minimum Data Set (MDS - a standardized assessment and screening tool) dated [DATE], indicated the resident had impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making with difficulties in memory and making needs known. The MDS indicated the resident was extensively dependent to totally dependent on staff for activities of daily living (ADLs - term used in healthcare to refer to daily self-care activities). A review of Resident 54's physician's orders dated [DATE] indicated that the resident was admitted to hospice care services (a set of care and services specialized in the needs for the dying resident) on [DATE] with a primary diagnosis of Heart Failure (a condition in which the heart no longer pumps enough blood for the body). (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent record review of Resident 54's medical record from [DATE] to [DATE] on [DATE] at 8:05 AM, Social Services Designee (SSD) stated, hospice care calendar for projected hospice services for the resident ended on [DATE] (15 days prior to). The SSD stated the last hospice care services visitation documentation was on [DATE] (12 days prior to). SSD stated the last hospice care plan was dated on [DATE] (7 months prior to) and that the certification for hospice services expired [DATE] (15 days prior to record review). 2. A review of Resident 108's Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of, but not limited to, dementia, (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change), Body mass index (BMI- a value derived from the mass and height of a person) less than 19.99 (An individual would be considered to be underweight if his/her BMI was in the range of 15 to 19.9), and atherosclerosis of aorta (the buildup of fats, cholesterol and other substances in and on the artery walls). A review of Resident 108's comprehensive admission Minimum Data Set (MDS - a standardized assessment and screening tool) dated [DATE], indicated the resident had impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making with difficulties in memory and making needs known. The MDS indicated the resident was extensively dependent to totally dependent on staff for activities of daily living (ADLs - term used in healthcare to refer to daily self-care activities). A review of Resident 108's physician's orders dated [DATE] indicated the resident was admitted to hospice care services (a set of care and services specialized in the needs for the dying resident) on [DATE] with a primary diagnosis of Alzheimer's disease (type of dementia that affects memory, thinking and behavior). A review of Resident 108's clinical record indicated no documented evidence of what type of services were provided by visiting hospice personnel from [DATE] to [DATE]. During an interview and concurrent record review of Resident 108's clinical record from [DATE] to [DATE] on [DATE] at 7:57 AM, Social Services Designee (SSD) stated, hospice care calendar for projected hospice services ended on [DATE] (6 months prior). The SSD stated, there were no hospice visitation documentation located in the resident's the chart. The SSD stated the last hospice care plan was dated on [DATE] (7 months prior) and that the certification for hospice services expired [DATE] (4 months prior). During an interview on [DATE] at 8:10 AM, the SSD stated that facility and the hospice services should coordinate care for the hospice residents residing in the facility. The SSD further stated hospice care should be coordinated so that the hospice and facility can take care of the residents needs and that it should include knowing when the hospice staff is coming, and the type of services being provided for the resident during hospice care visitation. During an interview on [DATE] at 10:00 AM, RN5 stated that it is important that the facility coordinates care with the hospice because the care for the hospice resident is very specialized. RN5 stated that it should be hospice care services should be coordinated to make sure the resident does not have pain or some other symptoms (that occur at end of line) and we (the facility should be aware of when the hospice staff members are coming so that they (the facility) can coordinate care. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled, Hospice Program, dated 2017, indicated that, it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative, which includes, communicating with the hospice provider (and documenting such communication) to ensure the needs of [NAME] resident are addressed. The policy also states that, the facility has designated SSD to coordinate care provided to the resident by our facility staff and hospice staff, and that he/she is responsible or obtaining, the most recent hospice plan of care specific to each resident and physician certification and recertification of the terminal illness specific to each resident.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46779 Based on observation, interview, and record review, the facility failed to ensure proper infection control practices was implemented for two of forty sampled residents (Resident 175 and Resident 87) in accordance with the facility's policy and procedure by: 1. Failing to ensure Resident 175's enteral tube feeding (food delivered directly into stomach) on the formula bottle was properly labeled with the date and time opened for one of 40 sampled residents (Resident 175). 2. Failing to ensure the urinary catheter (a tube placed into the body to drain and collect urine) of Resident 87 was not touching the floor This deficient practice placed Resident 175 and 87 at risk for infection and/ or serious illness. Findings: 1. A review of Resident 175's Admission Record indicated the facility admitted Resident 175, on 1/24/23, with diagnoses including cerebral infarction (stroke, damage to tissues in the brain due to a loss of oxygen to the area) and gastrostomy (creation of an artificial external opening into the stomach for nutritional support). A review of Resident 175's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 1/30/23, indicated the resident had severely impaired memory and cognitivity (ability to think and reason) and was totally dependent (full staff performance every time during entire 7-day period) with bed mobility, dressing, eating, toilet use and personal hygiene. During a review of Resident 175's Order Summary Report, dated 3/1/23, indicated Resident 175 was receiving Jevity (a formula provides complete, balanced nutrition for long- or short-term tube feeding) administer via continuous pump at rate of 55 milliliter (ml - unit of measurement) per hour for 20 hours, or until total volume was reached, providing 1100 ml per 1320 calories. The down time was from 9 AM to 1 PM. During a review of Resident 175's Medication Administration Record (MAR), dated 3/23, indicated Resident 175 received Jevity feeding formula via feeding pump from 3/01/23 until 3/15/23. During an observation, on 3/13/23 at 10:09 AM, Resident 175 was lying on her right side on the bed. Resident 175's gastrostomy tube's feeding pump was secured on an intravenous (IV, a way of giving a drug or other substance through a needle or tube inserted into a vein) pole (a medical device to provide a secure place to hang bags of medicine or fluid for administration to a patient) next to the resident's bed. The resident's G-tube feeding pump was currently off. An opened bottle of Jevity formula was observed hanging on the IV pole with feeding tubing primed through the feeding pump and being connected to Resident 175. Observed 350 ml of formula left in the Jevity formula bottle. (continued on next page)

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	056487	A. Building B. Wing	03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rio Hondo Subacute & Nursing Center	273 E Beverly Boulevard Montebello, CA 90640

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview, on 3/13/23 at 12:58 PM, the Licensed Vocational Nurse (LVN 11) stated she stopped the G-tube feeding at 9 AM as ordered for the bowel resting and she had not changed the formula bottle today. LVN 11 stated there was no opening/hung time and the nurse's initial on the Jevity formula bottle label. LVN 11 stated she only knew the formula bottle was hung on 3/12/23 and had been administered to Resident 175 since yesterday. LVN 11 stated she would not know when the bottle was opened and hung yesterday and if this formula bottle was still good at this time. LVN 11 stated the nurse should have written down the time that the formula bottle was opened and hung. LVN 11 stated each formula bottle should be changed every 24 hours. LVN 11 stated if the formula was used for over 24 hours, the formula would not be good, and bacteria would grow in the formula. LVN 11 stated this would place the resident at risk for infection. During an interview, on 3/15/23 at 1:09 PM, Registered Nurse (RN 1) stated the G-tube feeding bottle should be labeled with the resident's name, room number, nurse's initial, date, and time when it was opened and hung. RN 1 stated if the opening/hung time was not labeled, they would not know when the bottle was opened and hung and if the formula was still good. RN 1 stated G-tube feeding formula had to be changed every 24 hours. RN 1 stated if an opened formula was hung over 24 hours, this could place the resident at risk for infection because the risk of overgrowth of bacteria. During a review of the facility's policy and procedure titled, Enteral Tube Feeding Via Continuous Pump, dated November 2018, indicated on the formula label document initials, date, and time the formula was hung/administered. 42334 2. A review of Resident 87's admission record indicated resident was initially admitted on [DATE] with a readmission on 7/20/21 with a diagnosis of urinary tract infection (UTI- an infection in any part of the urinary system, the kidneys, bladder, or urethra (the duct in which urine moves out of the body), aphasia (loss of ability to produce or process language) following cerebral infarction (also known as a stroke, refers to damage to tissues in the brain due to a loss of oxygen to the area), and diabetes (a chronic condition that affects the way the body processes sugar). A review of Resident 87's comprehensive Admission MDS dated [DATE] indicated Resident 87 had impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making with difficulties in memory and making needs known. The MDS indicated the resident was extensively dependent to totally dependent on staff for activities of daily living (ADLs - term used in healthcare to refer to daily self-care activities). A review of Resident 87's history and physical dated 4/6/22 indicated, the resident did not have the capacity to understand and make decisions. A record review of Resident 87's physician's orders dated 1/26/23 indicated resident had a suprapubic catheter (drains urine from your bladder through a tube that is inserted into your bladder through a small hole in your belly and connected to a drainage bag). During an observation on 3/13/23 at 9:34 AM, Resident 87's suprapubic catheter drainage bag and tubing was observed hanging on the side of a low bed and resting on the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and concurrent interview on 3/13/23 at 10:57 AM, Licensed Vocation Nurse 13 (LVN13) stated, the urinary catheter tubing should not be touching the floor. LVN13 stated the floor is dirty and the catheter should not touch it. During an interview and concurrent policy record review on 3/15/23 at 12:17 PM, the Director of Nursing (DON) stated, the urinary catheter should not touch the floor and that the nurses have been instructed that it should not touch the floor. The DON stated, if the resident is on a low bed there should be something to block it (catheter bag and tubing) from touching the floor. The DON stated it was an infection control risk because the floor is dirty it can lead to resident's infection. The DON stated, the facility did not currently have a policy that specifically stated the catheter tubing and bag should not touch the floor. During a review of the facility's policy and procedure titled Infection Prevention and Control Program, revised 10/2018, indicated an infection prevention and control program (IPCP) is established and maintained to provide safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection. Important facets of infection prevention include educating staff and ensuring that they adhere to proper techniques and procedures.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46779 Based on observation, interview, and record review, the facility failed to provide a functioning call light (a device used by a resident to signal his or her need for assistance) for two of 40 sampled residents (Resident 61 and 177). This deficient practice had the potential to result in a delay in provision of assistance for the residents needs for toileting, hydration, activities of daily living. Findings: 1. A review of Resident 61's Admission Record indicated the facility admitted Resident 61 on 11/5/22 with diagnoses that included type II diabetes mellitus (a disease that affects how the body uses blood sugar) and dementia dementia (a general term to describe a group of symptoms related to loss of memory and judgment). A review of Resident 61's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 2/2/23, indicated Resident 61 had severely impaired memory and cognition (ability to think and reason). Resident 61 required supervision (oversight, encouragement, or cueing) with transferring and eating, and limited assistance (resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance) with dressing, toilet use and personal hygiene. During a concurrent observation and interview on 3/13/23, at 10:45 AM, with Resident 61, Resident 61 was closing her eyes and lying on the bed calmly. Resident 61's call light was on the floor and missing the pressing button on the call light. Resident 61 stated she did not know where call light was. Resident 61 shook her head when showed her where the call light was and asked if she could reach it on the floor. During a concurrent observation and interview on 3/13/23, at 10:48 AM, with licensed vocational nurse (LVN) 7, LVN 7 stated the call light was on the floor and was missing the pressing button on the call light. LVN 7 stated the call light was broken and she did know for how long the call light had been broken. LVN 7 stated Resident 61 could not use the call light for assistance if needed and it was important to always keep the call light functioning. During a concurrent observation and interview on 3/13/23, at 10:53 AM, with Director of Maintenance (DM), DM stated he was not aware of Resident 61's call light was broken until today. DM stated he would randomly check on four call lights each wing and all the call light in the shower room every day. DM stated the nurses would call and page him if there was a broken call light, and he would come immediately to fix it. DM stated to maintain a functioning call light was very important because of the residents' safety. During an interview on 3/13/23, at 3:48 PM, with RN 4, RN 4 stated the call lights should be always functioning, so the residents could ask for assistance and ensure their safety. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/15/23, at 11:15 AM, with DM, Call Light Logs, dated on 2/23, indicated DM last time checked on the call light in Resident 61's room was 2/16/23. DM stated he did not check on the call light in Resident 61's room after 2/16/23 or receive any report on the broken call light for Resident 61 until 3/13/23 morning. During a review of the facility's policy and procedure titled, Answering the Call Light, dated on 9/22, indicated Be sure that the call light is plugged in and functioning at all times. 46919 2. A review of Resident 177's Admission Record indicated Resident 177 was initially admitted on [DATE] with diagnoses that included seizures (a temporary disturbance in the electrical activity in the brain), reduced mobility, muscle weakness, and Diabetes Mellitus(a chronic condition that affects the way the body processes blood sugar). A review of Resident 177's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 2/06/23, indicated Resident 177 had severely impaired condition that required extensive assistance (resident involved in activity, staff provided weight-bearing support) with one-person assist with bed mobility, eating, and personal hygiene. Resident 177 required total dependence (full staff performance) with one to two-persons assist with dressing and toileting. A record review of Resident 177's Care Plan indicated Resident 177 at risk for falls (initiated on 2/07/23). Care plan intervention indicated to place call light within reach while in bed or close proximity to the bed and to remind to resident o use call light when attempting to ambulate or transfer. During the initial tour of the facility on 3/14/23, at 11:05 AM, Resident 177 observed in his room, lying in bed, awake and oriented but very upset. An interview with Resident 177 was conducted and resident stated he needed to get his changed. When informed that he can use his call light located next to his pillow to call staff for assistance, Resident 177 stated there was no point in using his call light because it has been broken since he was transferred to this room. During the interview with Resident 177, Certified Nursing Assistant 2 (CNA 2) walked in resident's room to check if Resident 177 needed assistance. During a concurrent observation and interview with CNA 2 on 03/14/23, at 11:14 AM, CNA 2 was unaware that Resident 177's call light was not functioning. CNA 2 was requested to check if Resident 177's call light was functioning and pressed the button three times. CNA 2 confirmed after the third try that the call light was not working. CNA verified that the light outside Resident 177's room did not light up after the call light button was pressed. CNA 2 stated Resident 177 was transferred from another room two weeks ago. CNA 2 stated that is the call light is not working, the resident will not be able to get assistance for water, incontinence care, or report falls. CNA stated that if the call light is broken it needs to be reported immediately to Charge Nurse or Supervisor. CNA 2 stated that the Maintenance Log is located in the Nurse's Station and maintenance checks the log every morning. During a concurrent interview and record review of the Maintenance Communication Log on 3/14/23, at 11:20AM, CNA 2 verified that the Maintenance Log did not have a report of broken call light for Resident 177. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Licensed Vocational Nurse 1 (LVN 4) on 03/14/23, at 11:26 AM, LVN 4 stated CNA 2 informed her today about Resident 177's broken call light. LVN 4 stated she immediately wrote the broken call light on the Maintenance Log. LVN 4 stated if there is a broken equipment, staff will try to fix it first if possible then write it on the Maintenance Log. LVN 4 stated Maintenance Department checks the log daily. LVN 4stated it is important the call light is working to know if the resident needs help. If the call light is broken, staff will not be able to meet the resident's needs. LVN 4 stated if a resident is incontinent, it is important to be able to call staff as soon as possible for incontinent care to prevent diaper rash or wound infection. LVN 4 stated Resident 177 transferred to his current room on 03/03/23. During an interview with Maintenance Director (MD) on 3/14/23, at 11:34 AM, MD stated he was unaware of Resident 177's broken call light. MD confirmed he replaced Resident 177's call light this morning after CNA 2 notified him. MD stated the red button on Resident 177's call light was pushed in. MD stated he checks the Maintenance Log every morning and everyday he checks four call lights and all the showers in the facility. MD stated it is important for residents to have a functioning call light to get assistance from staff when resident is in need. A record review of the facility's policy and procedure, revised on September 2022, titled Answering the Call Light, indicated to ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor. A record review of the facility's policy and procedure, revised on 1/26/21, titled Call Lights, indicated residents will have a call light or alternative communication device withing their reach at all times when unattended.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 47348 Based on observation and interview, the facility failed to maintain a functional, safe, and comfortable environment when: 1. The ceiling above the second-floor hallway was leaking water onto the floor. This deficient practice has the potential to cause injuries from slips and falls. 2. The screen door was not properly installed for a resident room. This deficient practice has the potential to allow vermin such as flies from entering the resident room. Findings: 1. During concurrent observation and interview, on 3/14/23 at 3:03 PM, water was leaking from the ceiling vent onto the second-floor hallway, in front of the conference room. A small bin and absorbent cloth were placed on the floor below the leak to catch the leaking water, along with a Caution: Wet Floor sign. No leaks observed on the ground floor resident care areas. Director of Maintenance (DM) stated that he already spoke with the repairmen from corporate office, who can begin making the repairs as soon as the rain slows down. 2. During concurrent observation and interview on 3/14/23 at 3:15 PM, a screen door was not detached from the sliding door frame of room for one resident room (Resident 17 and Resident 26). DM stated that the residents' family members/ visitors often remove the screen door for the resident.