STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555565	A. Building B. Wing	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Artesia Palms Care Center	11900 E. Artesia Blvd. Artesia, CA 90701

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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** 46415 Based on observation, interview, and record review, the facility failed to provide care in a manner that maintained or enhanced a resident's dignity and respect for two of seven sampled residents (Residents 80 and 100). This deficient practice had the potential to affect Resident 80 and Resident 100's self-esteem and self-worth. Findings: a. During a review of Resident 80's Admission Record (AR) the AR indicated Resident 80 was admitted to the facility on [DATE] and was last readmitted on [DATE] with diagnoses that included anxiety, insomnia (inability to fall asleep), schizoaffective disorder: bipolar type (mental health disorder that combines symptoms of hallucinations or delusions and mood disorders like mania and depression), unspecified psychosis (loss of contact with reality), unspecified atrial fibrillation (irregular heart rhythm), and hypertension (high blood pressure). During a review of Resident 80's the Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 11/9/2022, the MDS indicated Resident 80 had moderate cognitive (thought process) impairment but could make daily decisions. Resident 80 was totally dependent on staff for all activities of daily living ([ADL] activities related to personal care) except for eating, which Resident 80 required supervision. Resident 80 also exhibited verbal behavioral symptoms directed towards other (threatening, screaming, or cursing at others). During an interview on 1/24/2023 at 12:06 p.m. with Resident 80, Resident 80 stated he has been in the facility for a year and stated the staff do not treat him nicely. Resident 80 stated multiple staff have threatened him by saying, If you don't wise up, you'll end going to the grove (a unit in the facility). During an observation on 1/25/2023 at 1:39 p.m., Resident 80 was yelling very loudly using the language such as f*** you while Certified Nursing Assistant 4 (CNA 4) was present. CNA 4 was heard saying to Resident 80 that the facility will send him to the Grove Unit due to his behavior. (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 1/27/2023 at 9:43 a.m. with CNA 4, CNA 4 stated Resident 80 tends to yell and was often triggered by another resident within the same unit. CNA 4 stated when Resident 80 has outbursts, the staff deescalates the situation by telling the resident to calm down or they will send him back to the grove. CNA 4 stated other staff have said the same thing to Resident 80 as well. CNA 4 stated the statement does not feel threatening and stated, It calms the resident down. During an interview on 1/27/2023 at 10:01 a.m. with CNA 5, CNA5 stated she have heard other CNAs say the same thing to Resident 80. CNA 5 stated most of the CNAs tell Resident 80 the same thing. CNA 5 stated she have witnessed Resident 80 not getting care done due to Resident 80's attitude and stated CNAs would use it as an excuse to not provide patient care. CNA 5 stated she had complained about this issue to the supervisors, but nothing has been done. b. During a review of Resident 100's AR, the AR indicated Resident 100 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of intestinal tract (cancer of the intestinal tract), Type II diabetes mellitus (high blood sugar), dementia unspecified severity with other behavioral disturbance (group of symptoms affecting memory with mood disorders), anxiety disorder and an ileostomy (surgical opening where part of the small intestine is out to the surface of the skin). During a review of Resident 100's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 12/11/2022, the MDS indicated Resident 100 had moderate cognitive impairment but could make daily decisions. The MDS indicated Resident 100 required extensive assistance in toileting and personal hygiene, but otherwise was able to perform other activities of daily living ([ADL] activities related to personal care) with limited assistance. According to the MDS, Resident 100 did not use any assistive devices and was steady during ambulation. During an observation on 1/27/2023 at 2:15 p.m., Resident 100 was seen walking towards Licensed Vocational Nurse 17 (Registry nurse; LVN 17) requesting assistance. Resident 100 had a bulge on the right side of the torso and proceeded to show LVN 17 the ileostomy bag was full and was about to burst. It was LVN 17's first day at the facility and was not able to change the ileostomy bag and requested assistance. During the time of the resident requesting assistance, Resident 100 was seen coming in and out of the room continuing to request assistance from the nurses. During an interview on 1/27/2023 at 2:30 p.m., LVN 3 stated Resident 100's ileostomy bag was supposed to be changed every shift by the Treatment Nurse and he or she did notice the resident's ileostomy bag was full. LVN 3 stated Resident 100's ileostomy bag does not have a pocket to empty out the waste from the bag. LVN 3 stated the ileostomy bag was to be changed on an as needed basis. During an interview on 1/30/2023 at 8:58 a.m., with LVN 2 (treatment nurse), LVN 2 stated Resident 100's ileostomy bag was changed and checked every day to ensure the surrounding skin and stoma (opening in the body) was maintained. LVN 2 stated other nurses could also change the ileostomy bag and the CNA can assess the status of the ileostomy bag and notify the nurse to have it changed if needed. LVN 2 stated if the ileostomy bag overfills or was filled with gas, the ileostomy bag should be changed as it can burst. LVN 2 stated it was important to monitor the ileostomy bag as it can cause discomfort, pain, and may agitate the resident. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/30/2023 at 3:16 p.m. with the Director of Nursing (DON), the DON stated the Treatment Nurse was responsible for changing the ileostomy bag and the nurses should cover the Treatment nurse if unavailable. The DON stated if the ileostomy bag has a slot for the contents to be emptied, the CNA can empty the bag. The DON stated the ileostomy bag should be checked at least once a day and be monitored to ensure the bag was not too full. The DON stated if the ileostomy bag was not changed it can burst and can affect the resident's movement and if too full, the bag should be changed right away. During a review of the facility's policy and procedure (P/P) titled, Privacy/Dignity, dated 10/24/2017, the P/P indicated Employee must conduct themselves in a manner that is conductive to our facility's operational policies and processed as described in out mission statement and core values. During a review of the facility's P/P titled, Quality of Life Policy, dated December 2018, the P/P indicated It is the policy of this facility that residents will be cared for in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 45537 Based on observation, interview, and record review, the facility failed to ensure one of 39 sampled residents (Resident 240) was provided with assistance with her activity of choice, such as getting out of the bed and to sitting outdoors, as preferred. This deficient practice had the potential to negatively affect Resident 240's quality of life. Findings: During a review of Resident 240's Admission Record (AR), the AR indicated Resident 240 was admitted at the facility on 2/25/2022 with a diagnosis that included heart failure (heart does not pump blood as well as it should) and fibromyalgia (widespread muscle pain and tenderness). During a review of Resident 240's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 12/3/2022, the MDS indicated Resident 240 was able to make independent decisions that were reasonable and consistent, requires limited assistance with one person assist to complete her activities of daily living (ADLS) task such as bed mobility, transferring from bed to wheelchair and vice-versa and locomotion on and off the unit and/or care area. The MDS also indicated Resident 240's preference of activity was to go outside to get fresh air and it was of high importance to Resident 240. During a review of Resident 240's care plan on Activity, revised 11/1/2022 with a target date for 3/3/2023, the goal of the care plan indicated for Resident 240 to maintain involvement in cognitive stimulation and social activities as desired. The staff's interventions included introducing Resident 240 to residents with similar background and interests to facilitate interaction and to engage Resident 240 with preferred activities such as listening to music, socializing and enjoy the outdoors. During an observation and interview on 1/24/2023 at 12:47 p.m. with Resident 240, Resident 240 stated the staff told her she can only get up during her shower days and that makes her feel sad. Resident 240 stated the activity and nursing staff knows she wants to get out of bed to be able to talk to other people and get some sun because she loves the outdoors. During a concurrent observation and interview on 1/25/2023 at 1:40 p.m. with Resident 240, Resident 240 stated she told the nursing staff she wanted to get out of bed today but was not assisted with her request. Resident 240 stated she wanted to sit outdoors for a bit because she feels lonely in her room. During a concurrent observation and interview on 1/26/2023 at 12:59 p.m. with Resident 240, Resident 240 stated she was waiting for the nursing staff to help her get out of bed so she can go outdoors. During an observation on 1/26/2023 at 4 p.m., Resident 240 was napping in bed. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 1/27/2023 at 8:14 a.m. with Resident 240, Resident 240 stated she requested the nursing staff to assist her to get out of bed that day. Resident 240, with a sad facial expression on her face, stated the day before she was not assisted by the staff when she asked to get out of bed to enjoy her activity of choice that was why she just decided to take a nap. During an interview on 1/27/2023 at 8:25 a.m. with Restorative Nursing Assistant 1 ([RNA 1] an advanced CNA; have special training, skills and knowledge in therapeutic or rehabilitative techniques), RNA 1 stated he was always ready to coordinate with the certified nursing assistants (CNAs), should they need assistance in getting a resident out of bed. RNA 1 stated the CNAs can always coordinate with the activity personnel because there was no excuse for a resident not being assisted and accommodated with their needs, personal choices, and activity preferences. During an interview on 1/27/2023 at 8:40 a.m. with Activity Assistant 1 (AA 1), AA1 stated the nursing staff assists the residents to get out of bed and confirmed Resident 240 loves the outdoors and loves to talk to people. AA1 stated the activity personnel do not necessarily go with the residents outdoors because they have a lot to do, but AA1 stated if residents are not assisted with their activities of daily living and preferred activities, the residents will feel neglected and lonely. During an interview on 1/27/2023 at 8:53 a.m., with the RN 1 (Registered Nurse 1), RNS1 stated and confirmed Resident 240 would always ask to get out of bed and sit outdoors every day. RNS1 stated there is no excuse for the nursing staff not to accommodate Resident 240's needs and preferences because the resident will experience loneliness if she continues to stay in her room and have no constant interaction with others. During an interview on 1/27/2023 at 3:30 p.m. with the Director of Nursing (DON), the DON stated the nursing and activity staff must work hand in hand in making sure the residents' needs, choices and activity preferences are accommodated so they can enjoy and live a quality life. During a review of the facility's policy and procedure (P/P), revised 11/2012 and titled, Accommodation of Needs, the P/P indicated it was the policy of the facility to promote reasonable accommodation of residents' individual needs and preferences. During a review of the facility's P/P, revised 10/2018 and titled, Quality of Life Policy, the P/P indicated the residents will be cared for in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425 Based on interview and record review, the facility failed to ensure residents' medical records were updated to show documentation that advance directives (written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate) were discussed and written information was provided to the residents and/or responsible parties for 14 of 39 sampled residents (Residents 86, 50, 4, 175, 201, 99, 87, 183, 95, 63, 56, 80, 136, and 265). These deficient practices violated the residents' and/or the representatives' right to be fully informed of the option to formulate their advance directives and had the potential to cause conflict with the residents' wishes regarding health care. Findings: a. During a review of Resident 86's Admission Record (AR), the AR indicated an admitted [DATE] with a recent re-admitted [DATE]. According to the AR, Resident 86's diagnoses included dementia (the impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and schizoaffective disorder (mental disorder that affect thoughts, mood and behavior). b. During a review of Resident 50's AR, the AR indicated an admitted [DATE] with a recent re-admitted [DATE] with diagnoses including aphasia (difficulty with language or speech) and hemiplegia after cerebral infarct (paralysis of one side of the body after obstruction of blood flow in the brain). c. During a review of Resident 4's AR, the AR indicated an admitted [DATE] with a recent re-admitted [DATE] with diagnoses including major depressive disorder (condition characterized by a persistent depressed mood and long-term loss of pleasure or interest in life). d. During a review of Resident 175's AR, the AR indicated an admitted [DATE] with a recent re-admitted [DATE] with the diagnoses including major depressive disorder (condition characterized by a persistent depressed mood and long-term loss of pleasure or interest in life) and cerebral palsy (impaired muscle coordination due to damage to the brain before or at birth). e. During a review of Resident 201's AR, the AR indicated an admitted [DATE] with the diagnoses including hemiplegia after cerebral infarct (paralysis of one side of the body after obstruction of blood flow in the brain). f. During a review of Resident 99's AR, the AR indicated an admitted [DATE] with a recent re-admitted [DATE] with the diagnoses including schizoaffective disorder (mental disorder that affect thoughts, mood and behavior). g. During a review of Resident 87's AR, the AR indicated an admitted [DATE] with a most recent admitted [DATE]. The AR indicated diagnoses including transient ischemic attack ([TIA] a temporary disruption of blood flow to the brain) and epilepsy (seizure disorder). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	h. During a review of Resident 183's AR, the AR indicated an admitted [DATE] with a most recent re-admitted [DATE] with the diagnoses including major depressive disorder (condition characterized by a persistent depressed mood and long-term loss of pleasure or interest in life) and cerebrovascular disease (disorder that affects the blood vessels and blood supply to the brain). i. During a review of Resident 63's AR, the AR indicated an admitted [DATE] with a most recent re-admitted [DATE] with the diagnoses including schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions). j. During a review of Resident 95's AR, the AR indicated an admitted [DATE] with a most recent re-admitted [DATE] with the diagnoses including Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination) and major depressive disorder (condition characterized by a persistent depressed mood and long-term loss of pleasure or interest in life). k. During a review of Resident 56's AR, the AR indicated an admitted [DATE] with a most recent re-admitted [DATE] with the diagnoses including Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination). l. During a review of Resident 80's AR, the AR indicated an admitted [DATE] with a most recent re-admitted [DATE] with the diagnoses including schizoaffective disorder (mental disorder that affect thoughts, mood and behavior). m. During a review of Resident 136's AR, the AR indicated an admitted [DATE] with a most recent re-admitted [DATE] with the diagnoses including schizoaffective disorder (mental disorder that affect thoughts, mood and behavior). n. During a review of Resident 265's AR, the AR indicated an admitted [DATE] with a most recent re-admitted [DATE] with the diagnoses including schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions). During a concurrent interview and record review on 1/26/2023 at 10:52 a.m. with the Social Services Director 1 (SSD 1), the SSD 1 confirmed there was no advance directive acknowledgement form for the above 14 residents. The SSD 1 stated she would keep looking for them but at that moment what she provided was the only documentation that could be found. The SSD 1 stated she will have to provide an in-service to remind the social workers to provide and follow-up on the acknowledgement form. During a subsequent interview on 1/31/2023 at 8:24 a.m. with SSD 1, SSD 1 stated the acknowledgement form was significant because the form informed the residents and their responsible parties regarding the right to formulate an advance directive. During a review of the facility's policy and procedure (P/P), revised 11/2012 and titled, Advance Directives/DNR/Withholding treatment, the P/P indicated on admission the resident or decision maker would be notified of resident's rights to accept or refuse treatment and to formulate an advance directive.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425 Based on interview and record, the facility failed to ensure the Preadmission Screening and Resident Review (PASRR) screening was completed for one of 27 sampled residents (Resident 257). This deficient practice place Resident 257 at risk of not receiving the necessary specialized care and services. Findings: During a review of Resident 257's Admission Record (AR), the AR indicated an admitted [DATE] with diagnoses including gastroesophageal reflux disease ([GERD] condition in which acidic gastric fluid flows backward into the esophagus, resulting in heartburn), Type 2 diabetes mellitus, schizophrenia (a mental illness characterized by hearing and seeing things that are not there), and schizoaffective disorder, bipolar type (a mental illness characterized by hallucinations, delusions, and mood swings between mania and sometimes depression). During a review of Resident 257's Minimum Data Set (MDS), a standardized assessment and care-screening tool) dated 10/25/2022, the MDS indicated Resident 257 was cognition (thought process) was intact in decision-making with tasks regarding daily life and required supervision with ADLs (activities of daily living). During a review of Resident 257's PASRR level I screening document dated 10/20/2020, the document indicated Resident 257's level I screen was positive and required a level II evaluation. During a review of Resident 257's PASRR level II screening status document dated 2/10/2021, the document indicates the level II was attempted but due to isolation/ health and safety precautions it was not completed. During an interview on 1/30/2023 at 9:14 a.m. with the Admission Coordinator (AC), the AC stated Resident 257's PASRR level II was not completed due to the resident being in isolation. The AC stated nursing is contacted by the PASRR office regarding completion of PASRR level II screening. During an interview on 1/30/2023 at 2:15 p.m. with the Registered Nurse Supervisor 2 (RNS 2), RNS2 stated PASRR level II screening was completed over the telephone and if the resident was in isolation, the resident cannot come to the telephone. During an interview on 1/30/2023 at 3:15 p.m. with the Director of Nursing (DON), the DON stated the nursing staff was responsible for following up when the PASRR level II was not completed. The DON stated it was necessary to complete the level II because the level II provides specific recommendations regarding specialized care the resident requires. During a review of the facility's policy and procedure (P/P) titled Preadmission screening and resident review (PASRR) dated 7/2016, the P/P indicated recommendations from the determination letter will be included in the individual's plan of care.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46687 Based on observation, interview and record review, the facility failed to develop and implement residents' specific care plans for two of five sampled residents (Residents 183 and 875) at risk for accident and injury. 1. For Resident 183, who had dementia (impaired ability to remember, think or make decisions that interferes with everyday activities) and a behavior of wandering (traveling to places aimlessly) to other residents' room, was not being monitored of the whereabouts every two hours as indicated in the care plan. This failure had the potential for Resident 183 to have recurrent altercation with other residents and result in serious injury. 2. For Resident 875, who had history of suicide thought/ideation (having thoughts about ending one's own life), and attempted suicide, had no plan of care to indicate the staff's interventions to prevent recurrent suicide attempts. This failure had the potential for Resident 875 to repeat a suicide attempt and/or commit suicide that could lead serious injury and/or death. Findings: a. During a review of an investigation report, dated 11/5/2022 and timed at 10:31 a.m., the report indicated a certified nursing assistant reported to the licensed staff that Resident 183 hit another resident inside the room. According to the report, upon interview, Resident 183 appeared confused and was a poor historian but said he hit his roommate (Resident 2). During a review of Resident 2's Admission Record indicated the resident was admitted to the facility on [DATE] with the diagnoses that included, schizophrenia (serious mental disorder in which people interpret reality abnormally) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 2's Minimum Data Set (MDS), a comprehensive assessment of residents), dated 10/17/2022, the MDS indicated Resident 2 had moderate memory and cognitive (ability to think and reason) impairment that required supervision (oversight, encouragement or cueing) with set up only help on bed mobility, transfers and extensive assistance (resident involved in activity and staff provide weigh bearing support) on personal hygiene. During a review of Resident 183's Admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] and last readmitted on [DATE], with diagnoses that included major depressive disorder, anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread and uneasiness), dementia and schizophrenia. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 183's MDS, dated [DATE], the MDS indicated the resident had severe memory and cognitive (thought process) impairment with one-or three-days occurrences of verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others), supervision (oversight, encouragement or cueing) with set up only help on bed mobility, transfers and extensive assistance (resident involved in activity and staff provide weigh bearing support) on personal hygiene. During a review of Resident 183's Wandering Risk Assessment (WRA), dated 8/12/2022, the WRA indicated the resident was at moderate risk for wandering and history of wandering A review of Resident 183's care plan, revised on 11/16/2021 and 8/25/2021, the care plan indicated, Resident 183's was moderately at risk for wandering. The staff's interventions indicated the resident would be monitored every two hours for the whereabouts per the facility's protocol. During a review of another Resident 183's care plan, dated 4/26/2022, the care plan indicated Resident 183 had a potential to demonstrate physical aggression due to anger, dementia, and wandered to another resident room/ bed and sustained scratch marks to left hand from another resident. The staff's intervention included the facility will analyze the triggers (what cause the resident to react to certain stimuli), and de-escalates (to become less dangerous or difficult) behavior and document behavior. A review of Resident 183's Electronic Medication Record ([E-MAR] an electronic medication record) and Electronic Treatment Record ([E-TAR] an electronic treatment record) dated 10/2022 and 11/2022. The Liscensed Nursing Progress Notes (LPN) did not have documented evidence of Resident 183's whereabouts were being monitored every two hours as per the care plan; addressed what triggered the behavior and methods to deescalate the Resident 183's aggressive behavior as indicated in the resident's care plan. During a concurrent observation and interview on 1/24/2023 at 2:22 p.m., Resident 183 was sitting on the bed. In an interview, the resident was confused and was unable to recall the altercation incident with Resident 2 and could not answer further questions. During an observation on 1/24/2023 at 2:40 p.m., Resident 183 yelled at Certified Nursing Assistant 1 (CNA 1) and called CNA 1 an expletive (a swear word or phrase) name while CNA 1 attempted to put Resident 183's shoes on. During an interview on 1/24/2023 at 2:55 p.m., Resident 2 stated while he was lying in bed Resident 183 came into his room alone, opened his drawers and went through his belongings. Resident 2 stated he informed Resident 183 to leave his things alone but Resident 183 told him to move and yelled at him using expletive words. Resident 2 stated he stood up from his bed and Resident 183 approached him and hit him in the throat and neck. During an interview on 1/24/2023 at 3:17 p.m., LVN 1 stated the staff had a hard time with Resident 183 because he was non-compliant with care. LVN 1 stated there was nothing that stops Resident 183 from wandering to other units, unit rooms or beds because he was ambulatory. LVN 1 stated there was nowhere to document in Resident 183's record to indicate the resident's whereabouts, the staff would only keep an eye on the resident, but not document it. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/25/2023 at 3:09 p.m. with the Director of Nursing (DON), the DON stated licensed staff are responsible for documenting residents' whereabouts if indicated on the resident's care plan. The DON stated staff monitors, reorients, and give residents adequate supervision to know their whereabouts. The DON stated residents' whereabouts should be documented in the E-MAR or E-TAR, or the LPNs. The DON stated If there was no documentation in Resident 183's clinical records of the resident's whereabouts, it was either not done or not documented. A review of the facility's policy and procedure (P/P) revised 6/2017 and titled, Unsafe Wandering/Elopement Risk, the P/P indicated the facility will properly assess residents and plan their care to prevent unsafe accidents related to unsafe wandering behavior/elopement risks. The P/P indicated the resident's care plan shall address behavior using resident-specific goals and/or approaches as addressed by the interdisciplinary team. b. During a review of Resident 875's AR, the AR indicated the resident was admitted to the facility on [DATE] with diagnoses that included schizophrenia and major depressive disorder. During a review of Resident 875's MDS, dated [DATE], the MDS did not indicate if resident had cognitive impairment, that required supervision with set up only help with bed mobility, transfers, walking, and eating. According to the MDS, the resident required limited assistance (resident highly involved in activity; staff provided guided maneuvering of limbs or other non-weight bearing assistance) with personal hygiene. During a review of Resident 875's general acute care hospital (GACH) record, dated 10/24/2022 and titled, history and physical (H/P), the H/P indicated Resident 875 was admitted to the hospital due to suicide ideation and was referred to a psychiatrist for evaluation. During a review Resident 875's GACH Psychological Initial Evaluation dated 11/14/2022, the evaluation indicated Resident 875 was admitted twice to GACH for suicide ideation, verbalized having hallucinations (to see, hear, smell, taste or feeling things that appear to be but exist only in one's mind) and wanting to kill himself by overdosing of medication and shooting himself. According to the psychological evaluation, Resident 875 was placed on a 51/50 hold (involuntarily detained for a 72-hour in the hospitalization due to being a danger to others and self and/or being gravely disabled) due to being a danger to himself. During a review of Resident 875's Physician Progress Notes (PPN), dated 11/15/2022 and timed at 3:50 p.m. , the PPN indicated Resident 875 had suicidal thoughts, major depressive disorder, schizophrenia. The physician documented Resident 875 had suicidal thoughts and ordered to provide close monitoring and nursing to assess the resident for suicide thoughts. During a review of a Situation, Background, Assessment and Recommendation (SBAR; an internal communication form), used to facilitate and strengthen communication between nurses and prescribers, dated 11/19/2022 and timed at 10:12 p.m., the SBAR indicated Resident 875's roommate (Resident 3) claimed Resident 875 was trying to curl the call light string around his neck and the physician ordered Resident 875 to transfer to the hospital for further evaluation. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the incident report, dated 11/20/2022 timed at 2:14 p.m., the report indicated Resident 875's roommate came to the station and informed the staff that Resident 875 was curling the call light string in his neck. Resident 875 was assessed without injury and sent to the hospital for further evaluation and treatment. A review of Resident 3's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included anxiety disorder, major depressive disorder. A review of Resident 3's MDS dated [DATE], the MDS indicated the resident had no memory and cognitive impairment. During an interview of Resident 3 on 1/26/2023 at 9:47 a.m., Resident 3 stated he observed Resident 875 with a call light around his neck. Resident 3 stated Resident 875 He was really messed up and couldn't take it anymore. Resident 3 stated he observed Resident 875 whack himself with the call light string and pulled the call light around his neck as tight as possible. A review of Resident 875's care plan, initiated on 11/21/2022, the care plan indicated the resident had the potential for increasing behavioral issues, confusion, or disorientation due the roommate (Resident 3) claimed Resident 875 tried to curl the call light string in his neck on 11/20/2022. The plan of care did not indicated the interventions to be implemented to prevent Resident 875 from curling the call light around his neck or any other intervention to closely monitor and keep Resident 875's environment safe and removing objects that Resident 875 could use to commit suicide. During an interview with the DON on 1/30/2023 at 11:11 a.m., the DON stated everyone, including but not limited to nursing, social services and activities create a resident's care plan. The DON stated it was important to include all problems to be addressed from an outside facility into the care plan because its how they monitor resident's and it was a what are we going to do plan. The DON stated if a problem like suicidal thoughts/ideation was not included in a resident's care plan and they have a history of it, it may cause an exacerbation of those symptoms. The DON stated Resident 875's suicide attempt could have been avoided if a care plan for suicidal thoughts/ideation had been made for the resident. A review of the facility's policy and procedure (P/P), revised 11/2017 and titled, Care Plan- Baseline and Comprehensive, the P/P indicated the facility is to develop, upon admission and following completion of the Admission Nursing Assessment, an interim and comprehensive care plan. Comprehensive care plan must describe how services help attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47348 Based on interview and record review, the facility failed to ensure three of three sampled residents' (Residents 16, 108 and 232) care plans were reviewed and revised after a resident-to-resident altercations. This deficient practice resulted in Residents 16, 108 and 232 not having interventions to address their behaviors and placed other residents at risk for repeated resident to resident altercations. Findings: a. During a review of Resident 108's Admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses including bipolar type schizoaffective disorder (a mental health disorder marked by symptoms, including hallucinations and mood disorders such as depression). During a review of Resident 108's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 9/16/2022, the MDS indicated Resident 108 was cognitively (ability to think, understand and make daily decisions) impaired. During a review of Resident 108's Health Status Notes (HSN) dated 11/18/2022, the HSN indicated Resident 108 showed physical aggression toward Resident 189 on 11/18/2022. Resident 108 punched Resident 189 on the face while both residents were on the outside patio. During a review of Resident 108's Health Status Note (HSN), dated 11/21/2022, the HSN indicated Resident 108 struck Resident 114, while both residents were on the outside patio. During an interview on 1/24/2023 at 2:21 p.m. with Activity Assistant 1 (AA 1), AA 1 stated Resident 108 sometimes has outbursts such as cursing while passing by residents. During an interview with Resident 108 on 1/24/2023 at 2:36 p.m., Resident 108 stated, people are aggressive to him, and sometimes he hits back. Resident 108 stated he did not know the two residents that he had an altercation with, and that he does not remember attacking them. During an interview and concurrent record review of Resident 108's care plans with Licensed Vocational Nurse 11 (LVN 11) on 1/24/2023 at 3:48 p.m., Resident 108's care plan revisions after the resident-to-resident incidents on 11/18/2022 with Resident 189 and 11/21/2022 with Resident 114 were not found. LVN 11 stated there were care plans for Resident 108 related to previous physical aggression, but none were specific to the incidents dated 11/18/2022 and 11/21/2022. LVN 11 stated after a resident-to-resident incident, a care plan needed to be developed or updated to identify factors that led to the aggression and have interventions so that the incident will not happen again. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 1/25/2023 at 3:11 p.m., the DON stated the care plan should be updated after every resident-to-resident altercation to prevent the problem from repeating itself. The care plan revision should involve all the interdisciplinary team (IDT) members but mostly nursing staff. 46832 b. During a review of Resident 232's the Admission Record (AR), the AR indicated Resident 232 was admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia (a mental health disorder that causes a person to think, act, expresses emotion, perceives reality, and become paranoid of others) and bipolar disorder (a mental health disorder that causes extreme mood swings). During a review of the Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 12/19/2022, indicated Resident 232 was cognitively (ability to think, understand and make daily decisions) impaired. During a review of Resident 232's Nursing Progress Notes (NPN), the NPN indicated Resident 232 had a physical altercation with Resident 575 on 9/10/2022 after Resident 232 wandered into Resident 575's room. The NPN indicated Resident 575 asked Resident 232 to leave the room and when Resident 232 did not leave, Resident 575 hit Resident 232 on top of the head with a cane causing Resident 232 to sustain a superficial abrasion (skin scrape) and bump to the top of his head. During a review of Resident's 232 comprehensive care plans, the care plans indicated no documentation regarding interventions after the resident-to-resident altercation with Resident 575. During an interview on 1/25/2023 at 9:49 a.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated when residents get into altercations, staff will separate them soon as possible and call staff to help. Once the residents are separated, they are checked for injuries, determine if there were any witnesses, interview the residents to find out what started the altercation and call the doctor. LVN 1 stated Resident 232, likes to go in other residents' rooms and Resident 575 does not like it. LVN 1 stated Resident 232 was currently out of the facility. c. During a review of Resident 16's Admission Record (AR), the AR indicated Resident 16 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (a combination of symptoms of schizophrenia and mood disorder), autistic disorder (a group of developmental disabilities that can cause significant social, communication and behavioral challenges) and anxiety (intense, excessive, and persistent worry and fear about everyday situations). During a review of Resident 16's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 11/22/2022, the MDS indicated Resident 16 was cognition (ability to think, understand and make daily decisions) was intact. During a review of Resident 16's Nursing Progress Notes (NPN), the NPN indicated Resident 16 had a physical altercation with Resident 576 on 8/5/2022. The NPN indicated Resident 16 was out on the smoking break patio when Resident 576 began being verbally and physically aggressive and accusing Resident 16 of a stealing necklace. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident's 16's comprehensive care plans, indicated Resident 16's care plan was not revised after the resident-to-resident altercation with Resident 576. During an interview on 1/25/2023 at 3:09 p.m., with the Director of Nursing (DON), the DON stated, residents in the facility have mental health issues. The DON stated the facility process for resident-to-resident altercations included to separate the aggressor and victim and closely monitor them and place on one-on-one supervision if necessary. The DON stated a resident's care plan was updated for every resident-to-resident altercation after the incident. The DON stated after an altercation incident, nursing staff were responsible for updating the care plans. The DON stated updating the care plan was important to show what the facility was doing for the resident to avoid the incident from reoccurring. A review of the facility's policy and procedure (P/P) revised 11/8/2017 and titled, Managing Resident-to-Resident Altercations the P/P indicated the resident care plan will be reviewed, revised and updated as needed with added interventions and communicated to the staff caring for the resident. During a review of the facility's revised P/P dated 11/2017 and titled, Care Plan, Baseline and Comprehensive Policy, the P/P indicated a comprehensive person-centered care plan consistent with residents' rights will include measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 45537 Based on observation, interview, and record review, the facility failed to ensure the fingernails of one of 39 sampled residents (Resident 99) were clean and trimmed. This deficient practice resulted in Resident 99's left hand fingernails having accumulation of brown substance under the fingernails and had the potential to cause infection and impaired skin integrity. Findings: During a review of Resident 99's Admission Record (AR), the AR indicated Resident 99 was admitted at the facility on 10/26/2022 with a diagnosis that included generalized muscle weakness, difficulty in walking and dementia (thinking and social symptoms which includes memory loss and judgement which interferes with daily functioning). During a review of Resident 99's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 10/30/2022, the MDS indicated Resident 99 was not able to make independent decisions that were reasonable and consistent, requires extensive assistance with one-person physical assist to complete her activities of daily living (ADLS) task such as dressing and personal hygiene. During a review of Resident 99's comprehensive care plan, the comprehensive care plan did not indicate a care plan addressing the activities of daily (ADLS) task specific to the needs of Resident 99. During a concurrent observation and interview on 1/24/2023 at 12:27 p.m., with Resident 99, Resident 99's left hand fingernails had a considerable amount of brown substance underneath the untrimmed fingernails. Resident 99 had a puzzled look on her face while looking at her left-hand fingernails and stated her fingernails are brown and could not remember the last time she had a bath or a shower. During a concurrent observation and interview on 1/25/2023 at 2:30 p.m., with Resident 99, Resident 99 stated she was okay but looked puzzled while she showed her left-hand fingernails, which were still untrimmed and unclean with brown substance underneath the fingernails. During a concurrent observation and interview on 1/26/2023 at 12:18 p.m., with Resident 99, Resident 99 looked neat in her personal clothes but her fingernails on the left hand were still untrimmed and unclean with brownish substance underneath the nails. Resident 99 stated, I think I had a bath today. During a concurrent observation and interview on 1/26/2023 at 12:19 p.m., with CNA 2 (Certified Nursing Assistant 2), CNA 2 stated, I gave the resident a bath today. CNA 2 confirmed on observation, Resident 99's fingernails on the left hand were unclean and untrimmed. CNA 2 stated nail care and trimming was part of residents' proper hygiene and part of their activities of daily living. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/26/2023 at 12: 22 p.m., with Treatment Nurse 1 (TN 1), TN 1 stated it was part of the CNAs routine during the residents' ADL (activities of daily living; basic care such as showering, tolieting and grooming) care to make sure the residents' fingernails are cleaned and trimmed to prevent skin tears and infection related to substances accumulated underneath the resident's fingernails. During an interview on 1/26/2023 at 12:30 p.m. with Registered Nurse 1 (RN 1), RN 1 stated proper hygiene was included in the residents' ADL care. RN 1 stated care of the fingernails included cleaning and trimming to prevent skin tears and remove the possible cause of infection to the residents. During an interview on 1/26/2023 at 3:30 p.m. with the Director of Nursing Services (DON)), the DON stated the nursing staff must make sure the residents are assisted in their ADLS, which included, but not limited to showers and/ or bath and proper hygiene such as nail trimming and cleaning must be incorporated with their care to avoid complications of skin related injuries (skin tears) and infection. During a review of the facility's policy and procedure (P/P) revised 11/2012 and titled, Resident Care, Routine, the P/P indicated it was the policy of the facility to provide basic nursing care tasks for each resident based on the resident's individual needs which includes routine activities of daily living and the resident's personal cleanliness such as grooming (cleaning and trimming) of the residents' fingernails. During a review of the facility's P/P, revised 11/2012 and titled, Fingernails/Toenails, Care of, the P/P indicated it was the policy of the facility that nails are cleaned and trimmed regularly.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45382 Based on observation, interview, and record review, the facility failed to ensure one of eight sampled residents (Resident 44) had a physician's order before receiving treatment and care in accordance with professional standards of practice. Resident 44 received Restorative Nursing Assistant program ([RNA] nursing aide program that help residents to maintain their function and joint mobility program) without a physician's order. This deficient practice placed Resident 44 at risk for harm by receiving inappropriate services that were not recommended and/or prescribed by a physician. Findings: During an observation and interview on 1/24/2023 at 1:21 p.m., while in the resident's room, Resident 44 was lying in bed. Resident 44 was able to lift both arms to shoulder level, bend and straighten both elbows, and open and close the right hand. The small finger and ring finger of the left hand were bent. The middle finger of the left hand was unable to fully straighten. Resident 44 was able to bend both knees slightly and wiggle the toes of his left foot. Resident 44 stated staff visited him for exercises for both of his legs, but he did not like it. During a review of Resident 44's Admission Record (AR) the AR indicated the resident was originally admitted to the facility on [DATE] and last readmitted on [DATE]. The AR indicated Resident 44's diagnoses included sepsis (illness caused by the body's response to an infection), chronic obstructive pulmonary disease (lung disease that causes obstruction of airflow and can limit normal breathing), and epilepsy (disorder that causes episodes of seizures or altered consciousness). A review of Resident 44's Minimum Data Set (MDS), a comprehensive assessment and care-screening tool, dated 12/23/2022, the MDS indicated the resident was cognitively (mental processes involved in gaining knowledge and comprehension, includes thinking, knowing, remembering, judging, problem-solving) impaired. The MDS indicated Resident 44 required total assistance (full staff assistance) for bed mobility (moving in bed to and from different positions such as side to side), transfers (moving from one surface to another such as bed to chair), dressing, eating, personal hygiene, toilet use, and bathing. During a review of Resident 44's RNA Documentation Survey Report, dated 1/2023, the report indicated RNA task for RNA order for PROM to bilateral (both) lower extremities as tolerated once a day, five times a week to prevent risk of contracture. Initials of RNAs were documented on the following dates under the RNA task of passive range of motion (PROM) to both legs: 1/3/2023, 1/4/2023, 1/5/2023, 1/6/2023, 1/10/2023, 1/11/2023, 1/12/2023, 1/13/2023, 1/17/2023, 1/18/2023, 1/19/2023, 1/20/2023, 1/24/2023, and 1/25/2023. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review of Resident 44's Physician's Orders and RNA documentation on 1/26/2022 at 11:54 a.m., Licensed Vocational Nurse 1 (LVN 1) stated she supervised all the RNAs. LVN 1 stated RNA required a physician's order to provide services. LVN 1 confirmed Resident 44 did not have a physician's order for RNA services. LVN 1 confirmed RNA provided PROM exercises to both legs to Resident 44 on 1/3/2023 -1/6/2023, 1/10/2023 -1/14/2023, 1/17/2023 - 1/20/2023, 1/24/2023, and 1/25/2023 without a physician's order. LVN 1 stated the RNA order on 11/5/2022 was discontinued by the nursing supervisor, but the task was never discontinued. LVN 1 stated the RNA task should have been discontinued when the physician's order was discontinued but was not. LVN 1 stated the RNAs continued to provide services to Resident 44 despite discontinuation of the physician's order because the RNA task was never discontinued. LVN 1 stated RNA should not have been providing services because the RNA order was discontinued and there were no active RNA orders. During an interview on 1/31/2023 at 4:09 p.m., the Director of Nursing (DON) stated RNA exercises required a physician's order to provide the services. The DON stated if an RNA provided services without a physician's order, there was a potential for harm because the service provided may not be appropriate for the resident. A review of the facility's policy and procedure (P/P), revised 1/2014 and titled, Restorative Nursing Program, the P/P indicated a physician's restorative order will be written on the physician's order sheet by a licensed nurse or licensed therapist. The order will include specific information such as the type of activity to be performed, frequency of service, and any assistive or adaptive equipment needed. According to the P/P, the physician's order will be transcribed onto the monthly Restorative Nursing Flow Sheet and initialed by the RNA that completed the activity. The order will then be re-capped and printed monthly by the medical records department.

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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 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** 45382 Based on observation, interview, and record review, the facility failed to assess and monitor range of motion ([ROM] full movement potential of a joint) for three of three sampled residents (Residents 44, 56, and 94) on a quarterly basis to determine any changes in ROM in accordance with the facility's policy. This deficient practice had the potential for Residents 44, 56, and 94 to experience a decline in ROM and mobility and develop further contractures (loss of motion of a joint associated with stiffness and joint deformity). Findings: a. During an observation on 1/24/2023 at 1:21 p.m., while in Resident 44's room, the resident was observed lying in bed able to lift both arms to shoulder level, bend and straighten both elbows, and open and close the right hand. The small finger and ring finger of the left hand were bent. The middle finger of the left hand was unable to fully straighten. Resident 44 was able to bend both knees slightly and wiggle the toes of his left foot. A review of Resident 44's Admission Record (AR), the AR indicated the resident was originally admitted to the facility on [DATE] and last readmitted to the facility on [DATE] with diagnoses including sepsis (illness caused by the body's response to an infection), chronic obstructive pulmonary disease (lung disease that causes obstruction of airflow and can limit normal breathing), and epilepsy (disorder that causes episodes of seizures or altered consciousness). During a review of Resident 44's Minimum Data Set (MDS), a comprehensive assessment and care-screening tool, dated 12/23/2022, the MDS indicated the resident was cognitively (mental processes involved in gaining knowledge and comprehension, includes thinking, knowing, remembering, judging, problem-solving) impaired. The MDS indicated Resident 44 required total assistance (full staff assistance) for bed mobility (moving in bed to and from different positions such as side to side), transfers (moving from one surface to another such as bed to chair), dressing, eating, personal hygiene, toilet use and bathing. During a review of Resident 44's Rehab Screening record, dated 12/20/2022, the Rehab Screening record completed by a Physical Therapist did not include any measurable assessment and monitoring of Resident 44's range of motion. The Rehab Screening record indicated the following: - Reason for screening: Re-admission - Observation/Findings: Blank - Observation/Findings Comments: No observable functional change has occurred as per nursing, medical chart, and patient/caregiver interview. Will continue to monitor patient for s/sx (signs and symptoms) indicating the need for rehab. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Evaluations indicated: No evaluation required, Skilled Physical Therapy (PT) services is not recommended - Additional Comments: Continue nursing POC (plan of care) and RNA program for PROME (passive range of motion exercises, movement at a given joint with full assistance from another person) to BLE (bilateral lower extremities) as tolerated. b. During an observation on 1/24/2023 at 12:16 p.m., while the Resident 56's room, Resident 56 was awake and calm. Resident 56 was wearing hand splints (rigid material or apparatus used to support and immobilize a broken bone of impaired joint) on each hand. The left-hand splint extended from the forearm to the fingertips. The right arm had two splints: One splint extended from the right upper arm to include the elbow and ended at the forearm. The second splint extended from the right forearm to the palm. Resident 56's knees were bent. During an observation on 1/25/2023 at 10:40 a.m., while in Resident 56's room the resident 56 was lying in bed. Resident 56 was initially calm but became agitated. Both feet were resting in soft, cushion boots. Both legs were spread a part, both knees were bent, and both feet were pointing downwards. A review of Resident 56's AR, the AR indicated the resident was originally admitted to the facility on [DATE] and last readmitted to the facility on [DATE] with diagnoses including paraplegia (paralysis or weakness of the legs and lower body, typically caused by spinal injury or disease), anoxic brain damage (brain injury caused by lack of oxygen to the brain), and multiple contractures of both ankles, both feet, and both hands. During a review of Resident 56's Minimum Data Set (MDS), dated [DATE], the MDS indicated the resident had severe cognitive impairment. The MDS indicated Resident 56 required total dependence for bed mobility, transfers, dressing, eating, toileting, bathing, and personal hygiene. The MDS further indicated the resident had functional limitations in ROM on both arms and legs. A review of Resident 56's care plan, revised on 11/29/2018, the care plan indicated the resident had potential for contractures related to impaired mobility. The care plan goals for Resident 56's contractures indicated staff would notice any significant decline or limitation with ROM and the resident would have no further developing contractures. The care plan intervention indicated to assess and document Resident 56's joint mobility (brief assessment of a resident's range of motion in both arms and both legs) at least every quarter, document for changes, and obtain baseline ROM for comparison. During a review of Resident 56's Rehab Screening records, dated 10/31/2022, the Rehab Screening record completed by a Physical Therapist did not include any measurable, objective assessment of resident 56's range of motion. The Rehab Screening record included the following: - Reason for screening: Quarterly Review - Observation/Findings: Blank (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Observation/Findings Comments: Patient is bed-bound. Has old contractures (>[AGE] years) on both upper extremities (elbows and fingers) and both lower extremities (hips, knees, and ankles); non-ambulatory and dependent with all ADLs (activities of daily living, basic activities such as eating, dressing, and toileting) and functional mobility, has impaired cognition and unable to follow commands. Use of any orthotic device to BLE to correct the contracture is not recommended. - Evaluations indicated: No evaluation required; PT/OT (physical therapy/occupational therapy) are not indicated at this time. - Comments: Rehab screen was done. No noted change in strength or ROM has occurred compared from the previous screen as per nursing staff, medical chart and patient/caregiver interview. Continue RNA program for UE (upper extremity) splinting, and PROM to BUE and LE (lower extremities, legs). Will continue to monitor patient for s/sx (signs and symptoms) indicating the need for rehab. c. During an observation on 1/24/2023 at 1:49 p.m., while in Resident 94's room, Resident 94 was asleep in bed. Resident 94's left arm was bent at the elbow and resting behind the resident's head. The right arm had two splints: One splint extended from the right upper arm to include the elbow and ended at the forearm. The second splint extended from the right forearm to the palm. A blanket was covering both legs. A review of Resident 94's AR, the AR indicated the resident was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including Huntington's disease (an inherited disease in which the nerve cells in the brain break down over time) and contractures. During a review of Resident 94's Minimum Data Set (MDS) dated [DATE], the MDS indicated the resident was cognitively impaired. The MDS indicated Resident 94 required total assistance for bed mobility, transfers, dressing, eating, personal hygiene, toilet use and bathing. The MDS further indicated the resident had functional limitations in ROM on both arms and legs. During a review of Resident 94's Rehab Screening record, dated 8/12/2022, the Rehab Screening record completed by an Occupational Therapist did not include any measurable, objective assessment of Resident 94's range of motion. The Rehab Screening record indicated the following: - Reason for screening: Quarterly Review - Observation/Findings: Patient observed in bed - Evaluations indicated: No evaluation required - Additional Comments: No significant changes noted at this time, no skilled rehab services recommended at this time. Continue RNA to do PROM to BUE five times a week, every day as/or tolerated. During a review of Resident 94's Rehab Screening record, dated 12/7/2022, the Rehab Screening record completed by an Occupational Therapist did not include any measurable monitoring of Resident 94's range of motion. The Rehab Screening record indicated the following: - Reason for screening: Re-admission (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Observation/Findings: Blank - Observation/Findings Comments: Re-admission - Evaluations indicated: No evaluation required - Evaluation Comments: Re-admission - Additional Comments: Re-admission to facility. No skilled rehab necessary. Continue with RNA program. During a concurrent interview and record review on 1/27/2023 at 3:16 p.m., the Director of Rehabilitation (DOR), who was a Physical Therapist, stated functional Rehab Screens were conducted by a Physical Therapist or Occupational Therapist upon admission, quarterly, after a fall, and if there was a change in the resident's mobility status. The DOR stated the rehabilitation department did not perform joint ROM measurements and confirmed there were no objective, measurable information in terms of ROM in the Rehab Screens. The DOR stated the staff would only know if there was a decline in ROM if nursing informed them or if there was an observable decline in ADLs. The DOR reviewed Rehab Screenings for Residents 44, 56, and 94 and confirmed the records did not contain objective, measurable data to assess or monitor the resident's ROM. The DOR stated monitoring ROM was important to identify a potential decline in activities of daily living (basic activities such as eating, dressing, toileting). The DOR reviewed the facility policy titled, Assessment, Joint Mobility and stated the rehabilitation department did not follow the facility policy because they were a contract company (legal agreement or partnership between companies). The DOR stated the rehabilitation department followed their own undated policy, titled, Therapy Screenings Procedures and did not have a policy for joint assessment and/or monitoring. During an interview on 1/30/2023 at 3:24 p.m. with the Director of Nursing (DON), the DON stated nursing and the rehabilitation department were responsible for joint mobility assessments and monitoring. The DON stated the rehabilitation department established the range of motion baseline for all residents. The DON stated the facility relied on the RNAs to inform a licensed nurse or a therapist during the weekly RNA meetings if there was a decline in ROM when working with residents. The DON stated RNAs did not have the expertise or training to assess ROM but relied on the RNAs to detect any declines in ROM since the rehabilitation department and nursing did not conduct formal joint mobility assessments in the Rehab Screenings. The DON confirmed the policy Assessment, Joint Mobility, revised 11/2012 was the facility policy and stated all staff - contract and permanent - must follow the facility policy. The DON stated he never reviewed any policy the rehabilitation department stated they were following. The DON confirmed the rehabilitation department and nursing were not following the facility policy for joint ROM assessment. The DON stated there was a potential for contracture development and a decline in a resident's function if ROM was not being routinely assessed and monitored. During a review of the facility's policy and procedure (P/P) titled, Assessment, Joint Mobility, revised on 11/2012, the P/P indicated that all residents will be assessed for joint mobility limitations upon admission and at a minimum of every three months thereafter by a licensed therapist and nurse. The P/P indicated the following: Limitations in joint mobility will be defined in the following terms: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. FROM - full range of motion/no limitations b. Minimal - Represents a decrease in joint mobility of approximately 1% to 10% of the normal range of motion. c. Moderate - Represents a decrease in joint mobility greater than 10% to approximately 40% of the normal range of motion d. Severe - Represents a decrease in joint mobility greater than 40% to approximately 100% of the normal range of motion. The P/P also indicated that the Physical Therapist and Licensed nurse will assess each joint for range of motion and document findings. For each joint, indicate the degree of mobility. Date and then update reassessment and changes. This will show progress or lack of progress.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42506 Based on observation, interview, and record review, the facility failed to follow its policy to implement a visual identifier (a star) on a resident's door to indicate the resident had high risk for falls for one of one sampled resident (Resident 120) who had a history of multiple falls. The facility also failed to ensure all the staff were aware of its falling star program. This deficient practice had the potential to result in serious injury related to fall and failure to provide adequate supervision for residents who are high risk for falls. Findings: During a review of Resident 120's Admission Record (AR), the AR indicated Resident 120 was admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 120's diagnoses included Diabetes Mellitus Type 2 (abnormal blood sugar), dementia (a group of symptoms affecting memory, thinking and social abilities severely enough to interfere with daily functioning), schizophrenia (a mental disorder characterized by abnormal social behavior and failure to understand reality), other abnormalities of gait and mobility with lack of coordination; abnormal posture, and age related osteoporosis (disease that thins and weakens the bones). During a review of Resident 120's history and physical (H/P), the H/P indicated the resident had no capacity to make decisions. During a review of Resident 120's Minimum Data Set (MDS) a standardized assessment and care-screening tool, dated 11/9/2022, the MDS indicated the resident had moderately impaired cognition (thought process). According to the MDS, Resident 120 needed extensive assistance for bed mobility, transfer, walking, locomotion, dressing, toilet use, and personal hygiene. During a concurrent interview and record review with Licensed Vocational Nurse 1 (LVN 1) on 1/28/2023 at 10:35 a.m., LVN 1 stated Resident 120 takes Risperdal (medication to treat mental health disorder) and needs to be monitored for fall risks. LVN 1 stated Resident 120 was on a Falling Star Program since 2020. LVN 1 stated new staff can identify the residents who are at risk for falls when they see a star next to resident's name. LVN 1 stated if the staff was not aware of a fall risk, those residents will not receive frequent monitoring and supervision leading to potential fall or injury. During a concurrent observation and interview with LVN 12 on 1/28/2023 at 11:05 a.m., while outside Resident 120's room, there was no visual identifier (a star) outside the resident's door to indicate the resident was at risk for falls. LVN 12 stated no one oriented her about the Star Program with stars next to the names on the door to identify fall risk residents. During an interview with the Assistant Director of Nursing (ADON 1) on 1/28/2023 at 11:30 a.m., ADON 1 stated Resident 120 was a fall risk and needs to be monitored frequently and keep the resident within supervised view. ADON 1 stated Resident 120 was on the falling star program. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 120's care plan dated 1/6/2020, the care plan indicated Resident 120 was at risk for unavoidable fall and spontaneous fractures (broken bones). The goal indicated Resident 120 will remain free of injuries or complication related to falls. The care plan interventions indicated to anticipate needs of the resident, educate staff on supervision of residents's whereabouts, place a falling star identifier on resident's assistive device and outside of resident's door. During a review of the facility's policy and procedure (P/P) revised 11/2012 and titled, Falls Management, the P/P indicated residents will be assessed for fall risk and interventions will be implemented to reduce the risk of falls. The policy indicated residents who have sustained a fall, will be placed on the facility's heightened awareness program, which includes a visual identifier, (i.e Falling Star) designed to alert staff of a resident who has actively fallen in the presence of standard fall prevention interventions that have been on the care plan. Visual identifiers will be used to identify residents on the program.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46036 Based on observation, interview, and record review, the facility's staff failed to ensure residents with an indwelling urinary catheter (tube placed in the bladder to drain urine) received care and services to prevent infection by keeping the urinary catheter bag off the floor for one of two sampled residents (Resident 86). This deficient practice had the potential to place Resident 86 at risk for cross contamination and may result in a urinary tract infection. Findings: During a review of Resident 86's Admission Record (AR), the AR indicated Resident 86 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure (a serious condition that make it difficult to breathe), hypertension (high blood pressure) and acute kidney failure (occurs when the kidneys suddenly become unable to filter waste products from the blood). During a review of Resident 86's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 12/7/2022, the MDS indicated Resident 86 was cognitively (ability to think, understand and make daily decisions) impaired. According to the MDS, Resident 86 was totally dependent on staff for bed mobility, transfer, toilet use, and personal hygiene. During a review of Resident 86's Order Summary Report (OSR), for the month of 11/2020, dated 11/13/2022, the OSR indicated for the staff to provide indwelling catheter care every day per shift, keep drainage bag below bladder, and keep tubing free of dependent loops and kinks. The OSR also indicated to keep bag above floor every shift. During a review of Resident 86's care plan dated 12/19/2022, the care plan indicated the resident had an indwelling catheter and risk for further urinary tract infection ([UTI] bacteria enter the urethra and infect the urinary tract) related to impaired mobility and impaired cognition. The intervention included to provide care to the indwelling catheter every shift. During an observation on 1/24/2023 at 12:52 p.m., Resident 86 was awake, but not alert. The urinary catheter bag was on the floor. During an interview on 1/24/2023 at 12:55 p.m. with Registered Nurse 2 (RN 2), RN 2 stated, I see the resident's urinary bag is on the floor and it should be placed off the floor. It is important to keep the bag off the floor because it can contaminate the bag and cause a possible infection. During an interview on 1/30/2023 at 3:20 p.m. with the Director of Nursing (DON), the DON stated any urinary catheter bag should always be placed above the floor. The DON stated when the urinary bag touches the floor, it is considered contaminated and could possibly cause a UTI. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P/P) revised on 11/2012 and titled, Catheters, Urinary: Change Indwelling Urinary Catheters, the P/P indicated all types of urinary catheters will be used based on physician's orders and with appropriate care provided to reduce catheter-related infections or trauma.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46036 Based on observation, interview, and record review, the facility's staff failed to ensure residents received the necessary respiratory care and services for one of two sampled residents (Resident 170). Resident 170's humidifier was observed outdated for almost 30 days per the facility's policy and procedure. This deficient practice had the potential to place Resident 170 at risk breathing contaminated mist via the humidifier and can lead to possible infections. Findings: During a concurrent observation and interview on 1/24/2023 at 11:50 a.m. with Licensed Vocational Nurse 5 (LVN 5) Resident 170 was sitting in a wheelchair and an oxygen machine was placed at bedside. The humidifier (medical device used to humidify supplemental oxygen) attached to the nasal cannula was dated 12/28/2022 and the humidifier container (fluid) was almost empty. The outdated humidifier was pointed out to LVN 5 and LVN 5 agreed the humidifier was outdated and stated, It should be changed every week. A review of the Resident 170's Admission Record (AR), the AR indicated Resident 170 was admitted to the facility on [DATE] with diagnoses that included allergic rhinitis (allergic reaction that causes sneezing, congestion, itchy nose, and sore throat), hyperlipidemia (blood has too many fats; such as cholesterol), Type 2 diabetes mellitus (impairment in the way the body regulates and uses sugar as a fuel), and heart failure (occurs when the heart muscle does not pump blood as well as it should). During a review of Resident 170's Minimum Data Set (MDS) a comprehensive assessment and care-screening tool, dated 12/4/2022, the MDS indicated Resident 170 was alert and cognition (thought process) was intact. According to the MDS, Resident 170 required an extensive assistance from staff in bed mobility, transfer, dressing, and eating. A review of Resident 170's care plan dated 9/8/2022, the care plan indicated the resident had altered respiratory status/difficulty breathing. The listed goal indicated Resident 170 would not have symptoms of poor oxygen absorption. The staff's intervention included to monitor/document changes in orientation, increased restlessness, anxiety, and air hunger. During a review of Resident 170's physician's order dated 6/2/2020, the order indicated to start oxygen (O2) at 2 liter per minute (L/min) via nasal cannula (plastic tube placed into the nose) to keep O2 saturation above 92 percent (%) as needed for SOB (shortness of breath) give if O2 Sat is less (<) 92%. During an interview on 1/24/2023 at 12:15 p.m. with Registered Nurse 2 (RN 2), RN 2 stated licensed nurses should check if the resident needs oxygen therapy and when the humidifier was changed. RN 2 stated the humidifier needs to be changed every week or as needed and if not change timely, it would potentially deliver respiratory infection to the resident. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/30/2023 at 3:20 p.m. with the Director of Nurse (DON), the DON stated nurses should check the date the humidifier was changed before administering oxygen to the resident. The DON stated if residents receive oxygen via an outdated humidifier, it might cause possible infection associated possible contaminated air from the humidifier. During a review of the facility's undated policy and procedure (P/P) revised 11/2012 and titled, Oxygen (Emergency/documentation/humidifier/precautions/mode of delivery/storage/use/transporting), P/P indicated humidifier bottles will be dated and changed every 5 days per State Regulation.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 45537 Based on interview and record review, the facility failed to ensure three of three Licensed Vocational Nurses (LVNs 1, 9, and 10 [LVN 9 and 10 were registry nurses]) had completed competency skill training and specific competencies and skills sets necessary to care residents and ensuring LVNs 9 and 10 competency check list was done upon hire. This deficient practice had the potential for the licensed nursing staff to be ineffective in caring for the residents in the facility and has the potential for errors because of lacking competency skills. Findings: a. During a review on 1/30/2023 at 2:29 p.m. of LVN 1's personnel file, the file indicated the competency skills for LVN 1 was last done on 8/28/2017 (six years prior) and there was no evidence of any yearly competency skill assessment done for LVN 1 thereafter. During an interview on 1/31/2023 at 10:09 a.m. with LVN 1, LVN 1 stated she cannot remember when the last time she had completed the competency skills set but stated she have been in-serviced if the need arises. LVN 1 confirmed competencies must be done annually and was required by the facility. LVN 1 stated the Director of Staff Development (DSD) conducts the competencies and put the staff records altogether. During an interview on 1/31/2023 at 10:13 a.m. with the Assistant Director of Nursing 1, ADON 1 stated the competencies are done yearly so all the staff can be equipped on what their tasks and expectations needed to work in a care setting such as the facility. During a concurrent interview and record review on 1/31/2023 at 10:29 a.m. with the DSD, the DSD confirmed LVN 1's competencies has not been completed and was last updated in 2017. The DSD stated, All staff's competencies must be done annually and filed accordingly for the staff's educational development and skill reinforcement to empower the all staff to handle complex resident situations and care requirements, such as behavioral emergencies, abuse situations and the like. 45777 b. During a review of Resident 42's Admission Record (AR), the AR indicated the facility admitted the resident on 3/4/2022, with diagnoses that included paranoid schizophrenia (a mental health condition that affects how one think, feel, and behaves), anxiety disorder (feeling restless), and seizures (a sudden uncontrolled burst of electrical activity in the brain). (continued on next page)

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Artesia Palms Care Center	11900 E. Artesia Blvd. Artesia, CA 90701

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 42's Minimum Data Set (MDS), a standardized comprehensive assessment and care-screening tool, dated 12/8/2022, the MDS indicated the resident's cognition (the ability to think reason and understand) was moderately impaired. The MDS indicated the resident required supervision of a one-person physical assist with bed mobility (scooting, rolling turning in bed), dressing, toilet use, and personal hygiene. According to the MDS, the resident was receiving antipsychotics (medication to treat a mental health problems). During a review of Resident 42's Medication Administration Record (MAR), for the month of 1/2023, the MAR indicated the resident was to receive Depakote (used to treat seizure disorders, certain psychiatric conditions) tablet delayed release 250 milligram ([mg] unit of measurement) three tablets by mouth and Seroquel (an antipsychotic) 100 mg by mouth every morning at 9 a.m. as per the physician's orders. During a concurrent observation and interview on 1/26/2023 at 11:27 a.m. with Resident 42's nurse (LVN 9), LVN 9 stated the resident had been refusing her 9 a.m. medications every morning. LVN 9 stated Resident 42 was very agitated and yelling in the hallway. LVN 9 stated, I do not know the facility's policy regarding when to call the physician and I usually try three times to give the resident (Resident 42) her medications. I realize if I do not try to redirect the resident's behavior and notify her physician this resident could hurt or even kill someone. LVN 9 stated the facility's managers did not orientate her, probably because it becomes costly. During a concurrent observation and interview on 1/26/2023 at 11:40 a.m., Resident 42 was walking around the unit (Grove) yelling and hitting walls stating she was a doctor. Resident 42 walked to the writer's laptop and slammed it closed hitting the writer's fingers. A Registered Nurse Supervisor (RNS 2) saw the incident and went to notify the resident's physician. RNS 2 stated the facility's policy stipulated when a resident was showing unacceptable behavior, safety comes first, and the nurse was to protect the resident and redirect the behavior. RNS 2 stated if a resident refused to take their medications, the nurse should call the psychiatrist (a physician who specializes in mental illnesses). RNS 2 stated, A resident must not miss their medication dosage because the behavior can become worse. During an interview on 1/27/2023 at 10 a.m. with the Director of nursing (DON), the DON stated if a resident refused their medication, the nurse should continue to try to give it. The DON stated if the resident was exhibiting a behavior, the nurse must redirect the resident and call the physician right away and the physician may order Ativan as an intramuscular injection (into the muscle) to calm the resident down. The DON stated a missed dosage of a medication can result in the resident leaving the facility to get the medication readjusted. The DON stated it was important the resident receive their prescribed medications. c. During an observation and interview on 1/26/2023 at 10:11 a.m. with LVN 10, LVN 10 stated she did not know how to order missing medications. LVN 10 stated when she started working at the facility, she did not receive an orientation on the floor and/or make rounds with her. LVN 10 stated, I was told to be careful. During an interview on 1/31/2023 at 10:57 a.m. with the DON, the DON stated, I did not know the registry nurse had no orientation or competency check list when they arrived at our facility. The DON stated it was important to have the nurses' competencies on file, so they can know what training they have had and if they were competent enough for the job description. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/31/2023 at 4:04 p.m. with the Director of Staff Development (DSD), the DSD stated when a registry nurse was hired there was a competency evaluation form the facility receives. The DSD stated the facility does not have any competency check list for the registry nurses. The DSD stated it was important for our facility to have the registry's competency check list so our facility will know what the nurse are trained to do. During a review of the facility's policy and procedure (P/P), revised 5/7/2015 and titled, Knowledge and Skills Competency Evaluation, P/P indicated In an effort to provide optimal clinical care, direct care nursing staff are required to meet minimum standards before caring for residents. Knowledge and skills competencies are evaluated upon hire, annually thereafter and as needed, as indicated by job performance, newly introduced procedures, specific techniques required for an individual resident or new products and equipment.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42506 Based on observation, interview, and record review, the facility failed to sufficiently train two of two registry nurses to provide services as evidenced of two of two registry (outside contracted agency) licensed vocational nurses (LVNs 8 and 10) lacking knowledge of the facility's process in case of emergencies; the facility also did not provide dementia (a disease that impairs a person's ability to remember, think, or make decisions that interferes with doing everyday activities) training to ensure staff have the appropriate skills to provide care to residents with mental and psychosocial disorders according to its policy. These failure had the potential of the staff to not maintain safety in case of an emergency and provide necessary care and services to residents with dementia and psychosocial disorders which could result in psychosocial and emotional harm. Findings: a, During an observation on 1/25/2023 at 8:41 a.m., there was a verbal altercation between two residents (Residents 50 and 169) and Resident 50 pushed a side table in the room. During a concurrent observation and interview 8:43 a.m. with LVN 8 (registry nurse), LVN 8 who was passing medications, did not intervene. LVN 8 was asked what should be done when a resident escalate and becomes hostile, LVN 8 stated, I do not know what to do. During a concurrent observation and interview on 1/26/2023 at 10:18 a.m. with LVN 10, a registry nurse, LVN 10 stated it was her first day at the facility. LVN 10 stated, I didn't receive orientation of the unit and I am not aware of the codes used at the facility in case of emergencies. During an interview on 1/25/2023 at 9:51 a.m. with the director of staff development (DSD), the DSD stated orientation was given to all staff including registry staff regarding safety codes. The DSD stated if the staff are not aware of emergency codes it may affect residents' safety and had the potential for injury of residents and staff. During an interview on 1/25/2023 at 9:59 a.m. with the director of nursing (DON), the DON stated charge nurses(CN [LVN]) should know how to handle an escalated situation, the CN should reach out to the supervisor and call a specific code for additional assistance if needed. The DON stated If the CN was not aware of what to do in a particular situation the residents will not be safe, because behaviors can escalate and residents could get hurt. The DON stated the registry was responsible to give the registry nurses orientation to their own staff. The DON stated they only provide registry nurses a very brief overview. During a review of Resident 50's Admission Record (AR), the AR indicated Resident 50 was admitted to the facility initially on 9/18/2012 and last readmitted on [DATE]. According to the AR, Resident 50's diagnoses that included paranoid schizophrenia (a chronic mental health condition that affects a person's thoughts including delusions and hallucinations). (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 50's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 12/20/2022, the MDS indicated Resident 50 had severely impaired cognitive (thought process) skills for daily decision-making. The MDS indicated Resident 50 was always incontinent (inability to control) of urine and had a neurogenic bladder condition (urinary tract dysfunction due to brain, spinal cord or nerve problems), needs extensive assistant of a one-person assist with transfer and one person assist with dressing, eating, personal hygiene and toileting During a review of Resident 169's AR indicated Resident 169 was admitted to the facility initially on 4/25/2019 and last readmitted on [DATE]. According to the AR Resident 169's diagnoses included dementia (a group of symptoms affecting memory, thinking and social abilities severely enough to interfere with daily functioning), anxiety disorder (condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), schizoaffective disorder (mental condition characterized by abnormal thought processes and unstable mood), and bipolar disorder (a mental condition marked by alternating periods of elation [extreme happiness] and depression). During a review of Resident 169's MDS, dated [DATE], the MDS indicated Resident 169 had moderately impaired cognitive skills for daily decision making. During a review of facility's policy and procedure (P/P) revised 11/2012 and titled, Registry/ temporary Agency staff, the P/P indicated registry staff will be oriented to the facility and resident care and facility employees responsible for the orientation of registry personnel will be educated regarding the facility process. 45425 b. During an interview on 1/27/2023 at 8:30 a.m. with Restorative Nurse Assistant 2 (RNA 2), RNA 2 stated she had received dementia training more than once a year but could not remember exactly how many times it was provided by the facility. During an interview on 1/27/2023 at 8:32 a.m. with Registered Nurse 3 (RN 3), RN3 stated she have received dementia training at the facility every two years, which is provided online. During an interview on 1/27/2023 at 8:55 a.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 could not recall the last time she attended a class on dementia training. During an interview on 1/27/2023 at 11:48 a.m. with the Director of Staff Development (DSD), the DSD stated she started working in the facility in 8/2022 and she provided an in-service on 10/14/2022, and she was not sure of the dementia training being provided by the prior DSD. During a subsequent interview on 1/27/2023 at 1:46 p.m. with the DSD, the DSD stated if staff lacked the required dementia training, it would create a safety issue because staff would not know the appropriate ways to interact and care for the residents with dementia. A review of the facility's in-service attendance record sign in sheet indicated an in-service titled, Safety Precautions: Related to Dementia Residents was provided on 10/14/2022 for one hour. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/30/2023 at 3 p.m. with the Director of Nursing (DON), the DON was not sure of the frequency of dementia training. According to the DON, if staff do not receive dementia training, the staff will not know how to deal with the residents with dementia and the residents can become frustrated with the facility's staff. A review of the facility's policy and procedure (P/P) titled Care of Resident with Dementia and Behavior Assessment revised 6/2017, the P/P indicated staff should have two hours of training during orientation and five hours annually. During a review of the facility's Certified Nurse Assistant (CNA) job description, the job description indicated CNAs must be able to relate to and work with mentally ill, elderly and emotionally upset people within the facility and treat them with respect and consideration regardless of their cognitive or functional level. A review of the facility's Licensed Vocational Nurse (LVN) job description, the job description indicated LVNs must be able to relate to and work with mentally ill, elderly and emotionally upset people within the facility and treat them with respect and consideration regardless of their cognitive or functional level.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on observation, interview, and record review, the facility failed to: 1. Order refills for active medication orders consistently to ensure a continued supply of medications between 11/12/2022 and 1/26/2023 for two of six sampled residents (Residents 51 and 257). 2. Accurately account for 55 doses of controlled substances (medications with a high potential for abuse) affecting Residents 1, 76, 113, 163, and 204 in two of five inspected medication carts (Palm Terrace Middle and Palm Terrace West). These deficient practices increased the risk that Residents 1, 51, 76, 113, 163, 204, and 257 may not have received medication according to their physician's orders resulting in medical complications leading to an overall diminished quality of life. Findings: a. During a concurrent observation of medication administration and interview with Licensed Vocational Nurse 1(LVN 1) on 1/25/2023 at 8:28 a.m., LVN 1 was observed preparing the following medications for Resident 51: 1. One tablet of amlodipine (a medication used to treat high blood pressure) 5 milligrams ([mg] a unit of measure for mass) 2. One multivitamin tablet (a supplement) 3. One tablet of vitamin B1 100 mg (a supplement) 4. Two tablets of vitamin D3 (a supplement) international units ([IU] a unit of dose for vitamins) 5. One tablet of Farxiga (a medication used to treat high blood sugar) 10 mg 6. One tablet of finasteride (a medication used to treat prostate problems) 5 mg LVN 1 stated Resident 51 also has orders for metoprolol succinate (a medication used to treat high blood pressure) 50 mg, tamsulosin (a medication used to treat prostate problems) 0.4 mg, and fluoxetine (a medication used to treat mental illness) 10 mg due to be administered at 9 a.m., but they are currently out of stock. LVN stated the pharmacy was supposed to automatically send medication refills so she does not know why they are not there. LVN 1 stated she will follow up with the pharmacy to obtain the missing medications right away. An observation of the pharmacy label on the empty medication bubble pack (a card prepared by the pharmacy containing the individual doses of medications) for metoprolol succinate 50 mg showed it was last refilled for a fourteen-day supply on 12/26/2022. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation of the pharmacy label on the empty medication bubble pack for fluoxetine 10 mg showed it was last filled for a 14-day supply on 12/27/2022. An observation of the pharmacy label on the empty medication bubble pack for tamsulosin 0.4 mg showed it was last filled for a 30-day supply on 12/20/2022. During an interview on 1/25/2023 at 8:57 a.m., LVN 1 stated the six medications listed above were the only medications to administer to Resident 51 this morning besides the missing metoprolol succinate 50 mg, tamsulosin 0.4 mg, and fluoxetine 10 mg. LVN 1 stated she ordered the missing medications from the pharmacy and will administer them later when they arrive. During an observation on 1/252023 at 9 a.m., Resident 51 was observed taking all six medications listed above by mouth with water. A review of Resident 51's Admission Record (a document containing demographic and diagnostic information), dated 1/25/2023, the AR indicated Resident 51 was admitted to the facility on [DATE] and last readmitted [DATE] with diagnoses including essential hypertension (high blood pressure), Type 2 diabetes mellitus (a medical condition characterized by the body's inability to control blood sugar levels), major depressive disorder (a mental illness characterized by changed in mood, lack of energy, social withdrawal, and lack of interest in usually enjoyable activities), and chronic kidney disease (loss in kidney function over time leading to waste and fluid buildup in the blood). A review of Resident 51's Order Summary Report (a list of all currently active medical orders), dated 1/25/2023, the order indicated Resident 51 also had the following medications due to be administered every day at 9 a.m.: 1. Anoro Ellipta (a medication used to treat breathing problems) - inhale one puff by mouth once daily 2. Calcitriol (a medication used to treat low calcium for patients with bone or kidney disease) 0.25 mg by mouth once daily 3. Calcium carbonate (a supplement) 500 mg by mouth three times daily During an observation of medication administration with LVN 1 on 1/25/2023 at 9:03 a.m., LVN 1 was observed preparing the following medications for Resident 257: 1. One tablet of metformin (a medication used to control blood sugar)1000 mg 2. One and one-half tablets of fluvoxamine (a medication used to treat mental illness) 100 mg 3. One tablet of clonazepam (a medication used to treat mental illness) 1 mg 4. One tablespoon of a fiber supplement (a supplement used to aid bowel movements) mixed in approximately 4 ounces of water 5. One multivitamin tablet (a supplement) (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. One tablet of sennosides (a laxative used to aid bowel movements) 8.6 mg 7. One tablet of finasteride 5 mg (a medication used to treat prostrate problems) 8. One capsule of tamsulosin 0.4 mg 9. Three and one-half tablets of quetiapine (a medication used to treat mental illness) 100 mg During an interview on 1/25/2023 at 9:16 a.m., LVN 1 stated the nine medications listed above were the only mediations to administer to Resident 257 this morning. During an observation on 1/25/2023 at 9:21 a.m., Resident 257 was observed taking all nine medications listed above with water. A review of Resident 257's Admission Record (AR), dated 1/25/2023, the AR indicated the resident was admitted to the facility on [DATE] with diagnoses including Type 2 diabetes mellitus, schizophrenia (a mental illness characterized by hearing and seeing things that are not there), and schizoaffective disorder, bipolar type (a mental illness characterized by hallucinations, delusions, and mood swings between mania and sometimes depression). A review of Resident 257's Order Summary Report, dated 1/25/2023, the report indicated Resident 257 also had the following medications due to be administered every day at 9 a.m.: 1. Sodium Chloride (a supplement) 1 gm by mouth one time a day 2. Risperdone (a medication used to treat mental illness) 3 mg by mouth by mouth two times a day A review of Resident 51's Medication Administration Record ([MAR] a record of all medication administered to a resident), for the month of 1/2023, the MAR indicated LVN 1 marked Anoro Ellipta, calcium carbonate, and calcitriol as administered in the record for 9 a.m. on 1/25/2023. A review of Resident 257's MAR for 1/2023, the MAR indicated LVN 1 marked risperidone and sodium chloride as administered in the record for 9 a.m. on 1/25/2023. A review of the pharmacy delivery manifest, dated 12/23/2022, the manifest indicated the pharmacy delivered a 30 day-supply of tamsulosin 0.4 mg for Resident 51 on 12/23/2022 at 2:20 a.m If administered per the physician's orders, this supply would have been exhausted by 1/22/2023. A review of the pharmacy delivery manifest, dated 1/25/2023, the manifest indicated the next time the pharmacy delivered tamsulosin 0.4 mg for Resident 51 was on 1/25/2023 at 9:13 p.m A review of the pharmacy delivery manifest, dated 12/27/2022, the manifest indicated the pharmacy delivered a 14 day-supply of metoprolol succinate 50 mg for Resident 51 on 12/27/2022 at 6:37 p.m.,. If administered per the physician's orders, this supply would have been exhausted by 1/10/2023. A review of the pharmacy delivery manifest, dated 1/25/2023, the manifest indicated the next time the pharmacy delivered metoprolol succinate 50 mg for Resident 51 was on 1/25/2023 at 9:13 p.m (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the pharmacy delivery manifest, dated 12/29/2022, the manifest indicated the pharmacy delivered a 14 day-supply of fluoxetine 10 mg for Resident 51 on 12/29/2022 at 4:07 a.m If administered per the physician's orders, this supply would have been exhausted by 1/12/2023. A review of the pharmacy delivery manifest, dated 1/26/2023, the manifest indicated the next time the pharmacy delivered fluoxetine 10 mg for Resident 51 was on 1/26/2023 at 2:21 a.m. A review of the pharmacy delivery manifest, dated 11/1/2022, the manifest indicated the pharmacy delivered a 10 day-supply of calcitriol 0.25 mg for Resident 51 on 11/120/2022 at 10:13 p.m , If administered per the physician's orders, this supply would have been exhausted by 11/12/2022. A review of the pharmacy delivery manifest, dated 1/26/2023, the manifest indicated the next time the pharmacy delivered calcitriol 0.25 mg for Resident 51 was on 1/26/2023 at 3:53 a.m. A review of the pharmacy delivery manifest, dated 12/24/2022, the manifest indicated the pharmacy delivered a 14 day-supply or risperidone 3 mg for Resident 257 on 12/24/2022 at 3:34 p.m., If administered per the physician's orders, this supply would have been exhausted by 1/7/2023. A review of the pharmacy delivery manifest, dated 1/26/2023, the manifest indicated the next time the pharmacy delivered risperidone 3 mg for Resident 257 was on 1/26/2023 at 3:53 a.m A review of Resident 51's MAR, dated November 2022, the MAR indicated calcitriol 0.25 mg was administered on every day between 11/12/2022 and 11/30/2022 except for 11/17/22 when it was marked as unavailable. A review of Resident 51's MAR, dated December 2022, indicated calcitriol 0.25 mg was administered on every day between 12/1/2022 and 12/31/2022 except for 12/8/2022, 12/30/2022 and 12/31/2022 when it was marked as unavailable. A review of Resident 51's MAR, for the month of 1/2023, the MAR indicated calcitriol 0.25 mg was administered on every day between 1/1/2023 and 1/25/2023 except for 1/1/2023, 1/11/2023, 1/12/2023, and 1/13/2023 when it was marked as unavailable. A review of Resident 51's MAR, dated 1/2023, the MAR indicated tamsulosin 0.4 mg was marked as administered on 1/22/2023, 1/23/2023, and 1/24/2023 and was marked unavailable on 1/25/2023. A review of Resident 51's MAR, dated 1/2023, the MAR indicated metoprolol succinate 50 mg was marked as administered on every day between 1/10/2023 and 1/24/2023. A review of Resident 51's MAR, dated 1/2023, the MAR indicated fluoxetine 10 mg was marked as administered on every day between 1/12/2023 and 1/24/2023 and was marked as unavailable on 1/25/2023. A review of Resident 257's MAR, dated for the month of 1/2023, the MAR indicated risperidone 3 mg was marked as administered on every day between 9 a.m. on 1/7/2023 and 9 a.m on 1/25/2023 except for 9 a.m on 1/10/2023 and 5 p.m. on 1/11/2023 when it was marked as unavailable. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 1/25/2023 at 11:23 a.m. with the Registered Pharmacist (RPH), RPH confirmed the above dates and days of supply for Resident 51's metoprolol succinate 50 mg, tamsulosin 0.4 mg, calcitriol 0.25 mg and fluoxetine 10 mg were the most recent the pharmacy delivered. RPH stated there have been no other refills ordered or delivered for those medications between the date of fill on the prescription labels and today. RPH stated these medications were not delivered or filled for this resident under any other prescription numbers and based on the days of supply delivered, it looks like Resident 51 may have missed several consecutive days of those medications. During an interview on 1/25/2023 at 12:04 p.m. with LVN 1, LVN 1 stated metoprolol succinate, fluoxetine and tamsulosin have still not arrived from the pharmacy for Resident 51. LVN 1 stated she failed to administer the calcium carbonate or the calcitriol because she overlooked them. LVN 1 stated she marked the MAR that calcium carbonate and calcitriol were administered to Resident 51 even though they were not because she was nervous. LVN 1 stated there was currently no supply of calcitriol 0.25 mg capsules for Resident 51 available in her medication cart or anywhere else in the facility. LVN 1 stated she failed to administer the sodium chloride and risperidone to Resident 257 even though she also marked the MAR that they were administered at 9 a. m. LVN 1 stated there was currently no supply of risperidone for Resident 257 in her medication cart or anywhere else in the facility. LVN 1 stated failure to administer medications ordered by the physician may cause medical complications resulting in hospitalization or death. LVN 1 stated failure to administer psychiatric medications, including antipsychotics, could cause residents to experience psychiatric emergencies which could endanger the safety of that resident, other residents, or facility staff. LVN 1 stated documenting the MAR inaccurately in a way that it does not reflect care the resident actually received may mislead prescribers to make unnecessary dosage changes to medications possibly resulting in further medical complications. During an interview on 1/25/2023 at 3:44 p.m. with the DON, the DON stated the facility just transferred to an electronic medication refill system with their pharmacy. The DON stated the pharmacy was supposed to receive the refill order about three to four days ahead of time automatically based on the day-supply of medication previous dispensed for the residents. The DON stated the pharmacy can usually deliver those refills the next day. The DON stated if the electronic system fails, the nurses are responsible to notify the nurse supervisor or the pharmacy to request a refill for the resident. The DON stated neither he nor his staff conducts any oversight, such as periodic audits, of the pharmacy refill process to ensure it is working correctly but relies on the licensed staff to notify the pharmacy when medications are low to request a refill. The DON stated the facility leadership should implement some sort of oversight process due to residents being found without medications available for which they have active orders. The DON stated failing to administer medication according to the physician's orders may cause medical complications possibly resulting in hospitalization or death. The DON stated he was unaware that licensed staff were falsifying entries into the MAR to indicate medications were administered when they were not available in the facility. (continued on next page)

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	555565	A. Building B. Wing	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Artesia Palms Care Center	11900 E. Artesia Blvd. Artesia, CA 90701

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON stated he would determine which nurses were responsible for the falsified MAR entries and provide them one-on-one counseling and discipline as necessary. The DON stated the MAR must accurately reflect care provided to the residents otherwise it could cause medical providers to make unnecessary dosage changes to medications that could result in poor outcomes for the residents negatively affecting their quality of life. During an observation and concurrent interview of Palm Terrace Middle Medication Cart, on 1/26/2023 at 11:08 a.m. with LVN 4, the following discrepancies were found between the Controlled Drug Record (a log signed by the nurse with the date and time each time a controlled substance is given to a resident) and the medication card (a bubble pack from the dispensing pharmacy labeled with the resident's information that contains the individual doses of the medication): 1. Resident 1's Controlled Drug Record for clonazepam (a medication used to treat mental illness) 1 mg indicated there were 28 doses left, however, the medication card contained 27 doses. 2. Resident 163's Controlled Drug Record for alprazolam (a medication used to treat mental illness) 0.25 mg indicated there were 23 doses left, however, the medication card contained 22 doses. 3. Resident 163's Controlled Drug Record for hydrocodone/apap (a medication used to treat pain) 10/325 mg indicated there were 24 doses left, however, the medication card contained 23 doses. 4. Resident 76's Controlled Drug Record for tramadol (a medication used to treat pain) 50 mg indicated there were seven doses left, however, the medication card contained six doses. LVN 4 stated she administered all four missing doses of the controlled medications noted above that morning but failed to sign off on the controlled drug record after they were administered. LVN 4 stated she understands the policy was to sign the controlled drug record immediately after the medication was administered to maintain accountability over the controlled substances and to ensure residents are not given medications more often than they are prescribed. LVN 4 stated giving medications more often than prescribed could lead to medical complications. During an observation and concurrent interview of Palm Terrace [NAME] Medication Cart, on 1/26/2023 at 11:24 a.m. with LVN 5, the following discrepancies were found between the Controlled Drug Record (a log signed by the nurse with the date and time each time a controlled substance is given to a resident) and the medication card (a bubble pack from the dispensing pharmacy labeled with the resident's information that contains the individual doses of the medication): 1. Resident 113's Controlled Drug Record for hydrocodone/apap 5/325 mg indicated there were three doses left, however, the medication card contained two doses. 2. Resident 204's bubble pack containing 50 doses of lorazepam (a medication used to treat mental illness) 1 mg was found in the cart with no associated Controlled Drug Record available. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN 5 stated she administered the missing dose of hydrocodone/apap to Resident 113 that morning but failed to sign the controlled record after administering it. LVN 5 stated she understands the policy was to sign immediately after the administration to maintain accountability of the controlled substances and ensure residents do not receive medication more often than they're supposed to which might lead to harm. LVN 5 stated the lorazepam 1 mg for Resident 204 was discontinued on 12/22/2022 and should have been removed from the cart and given to the DON to store securely until it could be properly disposed of. LVN 5 stated when discontinued controlled substances are not removed from the cart, they are more at risk for diversion (illegal use) or possible accidental administration to residents. A review of the facility's policy and procedure (P/P) dated 4/2008 and titled, Ordering and Receiving Medications from the Dispensing Pharmacy, the P/P indicated Medications and related products are received from the dispensing pharmacy on a timely basis . If not automatically refilled by the pharmacy, repeat medications (refills) are written on a medication order form/ordered by peeling the bottom part of the pharmacy label and placing it in the appropriate area on the order form provided by the pharmacy for that purpose and ordered as follows: Reorder medication five days in advance of need to assure an adequate supply is on hand . The refill order is called in, faxed, or otherwise transmitted to the pharmacy . During a review of the facility's P/P dated 4/2002 and titled, Storage of Medications, the P/P indicated Outdated, contaminated, or deteriorated medications . are immediately removed from stock, disposed of according to procedures for medication disposal . 45425 b. During an interview on 1/24/2023 at 10:30 a.m. with Resident 257, Resident 257 stated sometimes the facility runs out of his medications such as pantoprazole (medication used to treat heartburn, acid reflux and gastro-oesophageal reflux disease [GERD]). Resident 257 stated when the facility orders the medications, the medications take a while to be delivered. During a review of Resident 257's Order Summary Report dated 1/25/2023, the report indicated a physician order Pantoprazole sodium tablet delayed response 40 milligram ([mg] unit of measurement), give 40 mg by mouth in the morning related to GERD without esophagitis (inflammation of the esophagus). During a review of the pharmacy's delivery manifest, dated 12/30/2022, the manifest indicated the pharmacy delivered a 14 day supply of pantoprazole 40 mg for Resident 257 on 12/20/2022 at 12:36 a.m. If administered per the physician's order, this supply would have been completed by 1/13/2023. During a review of the pharmacy's delivery manifest, dated 1/21/2023, the manifest indicated the next time the pharmacy delivered pantoprazole 40 mg for Resident 257 was on 1/21/2023 at 3:50 p.m. During an interview on 1/30/2023 at 2:15 p.m. with the Director of Nursing (DON), the DON confirmed from the delivery dates, there was no supply of pantoprazole for Resident 257 from 1/14/2023-1/21/2023 (7 days). The DON stated Resident 257 could potentially have had negative outcomes due to lack of medication administration of pantoprazole. The DON stated the nurse should have called the pharmacy if the medication was not available. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P/P) dated 4/2008 and titled, Medication Administration-general guidelines the P/P indicated medications should be administered in accordance with written orders. During an interview on 1/24/2023 at 10:30 a.m. with Resident 257, Resident 257 stated sometimes the facility runs out of his medications such as pantoprazole. Resident 257 stated when the facility orders the medications, the medications take a while to be delivered. A review of Resident 257's Admission Record, dated 1/25/2023, the AR indicated the resident was admitted to the facility on [DATE] with diagnoses including GERD, Type 2 diabetes mellitus, schizophrenia (a mental illness characterized by hearing and seeing things that are not there), and schizoaffective disorder, bipolar type (a mental illness characterized by hallucinations, delusions, and mood swings between mania and sometimes depression.). During a review of Resident 257's Order Summary Report dated 1/25/2023, the report indicated a physician order for Pantoprazole sodium tablet delayed response 40 mg, give 40 mg by mouth in the morning related to gastro-esophageal reflux disease without esophagitis. During a review of the pharmacy delivery manifest, dated 12/30/2022, the manifest indicated the pharmacy delivered a 14-day supply of pantoprazole 40 mg for Resident 257 on 12/20/2022 at 12:36 a.m If administered per the physician's order, this supply would have been exhausted by 1/13/2023. During a review of the pharmacy delivery manifest, dated 1/21/2023, the manifest indicated the next time the pharmacy delivered pantoprazole 40 mg for Resident 257 was on 1/21/2023 at 3:50 p.m During an interview on 1/30/2023 at 2:15 p.m. with the Director of Nursing (DON), the DON confirmed from the delivery dates, there was no supply of pantoprazole for Resident 257 from 1/14/2023-1/21/2023. The DON stated Resident 257 could potentially have negative outcomes due to lack of medication administration of pantoprazole. The DON stated the nurse should have called the pharmacy if the medication was not available. During a review of the facility's policy and procedure (P/P) titled Medication Administration-general guidelines dated 4/2008, the P/P indicated medications should be administered in accordance with written orders.

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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** 40994 Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five percent (%). Seventeen medication errors out of 44 total opportunities contributed to an overall medication error rate of 38.64 % affecting three of six residents observed for medication administration (Residents 51, 200, and 257.) The medication errors were as follows: 1. Omitted or late administration of metoprolol succinate (a medication used to treat high blood pressure) 50 milligrams (mg - a unit of measure for mass) for Resident 51 2. Omitted or late administration of tamsulosin 0.4 mg (a medication used to treat prostate problems) for Resident 51 3. Omitted or late administration of fluoxetine 10 mg (a medication used to treat mental illness) for Resident 51 4. Omitted or late administration of Anoro Ellipta (a medication used to treat breathing problems) for Resident 51 5. Omitted or late administration of calcium carbonate (a supplement) 500 mg for Resident 51 6. Omitted or late administration of calcitriol (a medication used to treat low calcium for patients with bone or kidney disease) 0.25 mg for Resident 51 7. Omitted or late administration of sodium chloride (chemical name for salt; an electrolyte that regulates the amount of water in your body) 1 gram ([gm] a unit of measure for mass) for Resident 257 8. Omitted or late administration of risperidone (a medication used to treat mental illness) 3 mg for Resident 257 9. Late administration of Admelog (a type of insulin used to treat high blood sugar) for Resident 200 10. Wrong dose of vitamin C (a supplement) administered for Resident 200 11. Wrong dose of vitamin D3 (a supplement) administered for Resident 200 12. Omitted or late administration of clopidogrel (a medication used to prevent stroke) 75 mg for Resident 200 13. Omitted or late administration of multivitamin (a supplement) for Resident 200 14. Omitted or late administration of ferrous sulfate (a supplement) for Resident 200 15. Omitted or late administration of sodium chloride 1 gm for Resident 200 (continued on next page)

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F 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	16. Omitted or late administration of zinc sulfate (a supplement) 220 mg for Resident 200 17. Omitted or late administration of lactobacillus (a supplement) for Resident 200 This deficient practice of failing to administer medications in accordance with the physician's orders increased the risk that Residents 51, 200, and 257 may have experienced serious medical complications such as stroke (occurs when something blocks blood supply to part of the brain or when a blood vessel in the brain bursts) or complications related to poor blood sugar or blood pressure control possibly resulting in hospitalization and/or death. This deficient practice of failing to administer psychiatric (relating to mental illness or its treatment) medications to Residents 51 and 257 could have resulted in a psychiatric emergency possibly threatening the resident's safety, the safety of other residents, and facility's staff. On 1/25/2023 at 4:08 p.m., in the presence of the Administrator (ADM), Director of Nursing (DON), and the Assistant Administrator (AADM) an Immediate Jeopardy ([IJ] a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) situation was identified, and declared due to the facility's failure to ensure that its medication error rate was less than 5%. The medication error rate was 38.64 % On 1/27/2023 at 12:26 p.m., the facility provided the Department of Public Health with an Immediate Jeopardy Removal Plan (IJRP) containing the following summarized actions: 1. On 1/25/2023 at 4:30 p.m., a change of condition was initiated for Residents 51, 200, and 257. Residents will be monitored for side effects of medication omissions for 72 hours and any adverse reaction shall be reported timely to the physician. A plan of care for medication omission was initiated. The Medical doctor and responsible party were informed of the resident change in condition. Medications that were not available for Residents 51, 200, and 257 were ordered from the pharmacy by the licensed staff. 2. On 1/25/2023 at 6 p.m., the facility began a medication cart audit of the residents' medication by checking each resident medication order and checking the availability of the medication in the medication cart. 3. In-service was initiated by the DON or designee on 1/25/2023 at 6 p.m. for licensed nurses regarding medication administration guidelines. 4. Medication pass competency skills check was initiated on 1/25/2023 by the DON or designee. 5. The DON or designee shall provide counseling, one-to-one in-service to licensed nurses involved with the deficient practice on medication administration guidelines starting on 1/26/2023. 6. Physician or nurse practitioner visits were scheduled for 1/26/2023. 7. The licensed nurses will be educated on the policy and expectation for the completion of accurate and timely documentation in the Medication Administration Record ([MAR] - a record of all medication administered to a resident). The education will also include medication ordering protocols to ensure that medications ordered by the physician are ordered and available for timely medication pass. (continued on next page)

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F 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	8. The licensed nurses will be educated on the medication error policy and expectations. This education will include omitted medications, medications unavailable, errors in administration and medication not administered timely. 9. The facility contacted the pharmacy and scheduled an on-site assistance for training and monitoring. 10. The facility's medication administration guidelines were revised to include the role of the licensed nurse when ordering medications not available during med pass. On 1/28/2023 at 1:42 p.m., while onsite, after verification through observation, interview, and record review the facility's implementation of the IJ immediate corrective actions, the Immediate Jeopardy was removed, in the presence of the ADM, DON, and the AADM. Findings: a. During a concurrent observation of medication administration and interview with the Licensed Vocational Nurse 1 (LVN 1) on 1/25/2023 at 8:28 a.m., LVN 1 was observed preparing the following medications for Resident 51: 1. One tablet of amlodipine (a medication used to treat high blood pressure) 5 mg 2. One multivitamin tablet 3. One tablet of vitamin B1 100 mg (a supplement) 4. Two tablets of vitamin D3 1000 international units (IU - a unit of dose for vitamins) 5. One tablet of Farxiga (a medication used to treat high blood sugar) 10 mg 6. One tablet of finasteride (a medication used to treat prostate problems) 5 mg LVN 1 stated Resident 51 also has physician orders for metoprolol succinate 50 mg, tamsulosin 0.4 mg, and fluoxetine 10 mg due to be administered at 9 a.m., but they are currently out of stock. LVN 1 stated the pharmacy was supposed to automatically send medication refills, but she does not know why the medications were not there. LVN 1 stated she will follow-up with the pharmacy to obtain the missing medications right away. During an observation on 1/25/2023 at 8:50 a.m., the following was observed of the pharmacy's labels: 1. The pharmacy label on the empty medication bubble pack (a card prepared by the pharmacy containing the individual doses of medications) for metoprolol succinate 50 mg showed it was last refilled for a fourteen day-supply on 12/26/2022. 2. The pharmacy label on the empty medication bubble pack for fluoxetine 5 mg showed it was last filled for a fourteen day-supply on 12/27/2022. (continued on next page)

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F 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. The pharmacy label on the empty medication bubble pack for tamsulosin 0.4 mg showed it was last filled for a 30 day-supply on 12/20/2022. During an interview on 1/25/2023 at 8:57 a.m., LVN 1 stated the six medications listed above were the only medications to administer to Resident 51 that morning besides the missing metoprolol succinate 50 mg, tamsulosin 0.4 mg, and fluoxetine 10 mg. LVN 1 stated she ordered the missing medications from the pharmacy and will administer them later when they arrive. During an observation on 1/25/2023 at 9 a.m., Resident 51 was observed taking all six medications listed above by mouth with water. A review of Resident 51's Admission Record ([AR] a document containing demographic and diagnostic information), dated 1/25/2023, the AR indicated Resident 51 was admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 51's diagnoses included essential hypertension (high blood pressure), Type 2 diabetes mellitus (a medical condition characterized by the body's inability to control blood sugar levels), major depressive disorder (a mental illness characterized by changed in mood, lack of energy, social withdrawal, and lack of interest in usually enjoyable activities), and chronic kidney disease (loss in kidney function over time leading to waste and fluid buildup in the blood.) A review of Resident 51's Order Summary Report (a list of all currently active medical orders), dated 1/25/2023, the summary report indicated Resident 51 also had the following medications due to be administered every day at 9 a.m.: 1. Anoro Ellipta - inhale one puff by mouth once daily 2. Calcitriol 0.25 mg by mouth once daily 3. Calcium carbonate 500 mg by mouth three times daily b. During an observation of medication administration with LVN 1 on 1/25/2023 at 9:03 a.m., LVN 1 was observed preparing the following medications for Resident 257: 1. One tablet of metformin (a medication used to control blood sugar)1000 mg 2. One and one-half tablets of fluvoxamine (a medication used to treat mental illness) 100 mg 3. One tablet of clonazepam (a medication used to treat mental illness) 1 mg 4. One tablespoon of a fiber supplement (a supplement used to aid bowel movements) mixed in approximately 4 ounces of water 5. One multivitamin tablet 6. One tablet of sennosides (a laxative used to aid bowel movements) 8.6 mg 7. One tablet of finasteride 5 mg (continued on next page)

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F 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	8. One capsule of tamsulosin 0.4 mg 9. Three and one-half tablets of quetiapine (a medication used to treat mental illness) 100 mg During an interview on 1/25/2023 at 9:16 a.m., LVN 1 stated the nine medications listed above were the only mediations to administer to Resident 257 that morning. During an observation on 1/25/2023 at 9:21 a.m., Resident 257 was observed taking all nine medications listed above with water. A review of Resident 257's AR, dated 1/25/2023, the AR indicated the resident was admitted to the facility on [DATE] with diagnoses including Type 2 diabetes mellitus, schizophrenia (mental illness characterized by hearing and seeing things that are not there), and schizoaffective disorder, bipolar type (a mental illness characterized by hallucinations, delusions, and mood swings between mania and sometimes depression). A review of Resident 257's Order Summary Report, dated 1/25/2023, the summary report indicated Resident 257 also had the following medications due to be administered every day at 9 a.m.: 1. Sodium Chloride 1 gm by mouth one time a day 2. Risperidone 3 mg by mouth by mouth two times a day c. During an observation of medication administration with LVN 2 on 1/25/2023 at 9:33 a.m., LVN 2 was observed preparing 18 units (a measure of dose for insulin) of Admelog for Resident 200. During an observation on 1/25/2023 at 9:38 a.m., LVN 2 was observed administering 18 units of Admelog insulin by subcutaneous (under the skin) injection into Resident 200's left lower abdomen. During an observation of medication administration and concurrent interview with LVN 2 on 1/25/2023 at 9:42 a.m., LVN 2 was observed preparing the following medications for Resident 200: 1. One tablet of Farxiga 10 mg 2. One tablet of icosapent ethyl (a medication used to lower cholesterol) 1 gm 3. One tablet of losartan (a medication used to treat high blood pressure) 25 mg 4. One tablet of magnesium oxide (a supplement) 5. One tablet of metformin 1000 mg 6. One tablet of metoprolol tartrate (a medication used to treat high blood pressure) 25 mg 7. One tablet of vitamin B-6 (a supplement) 25 mg 8. One tablet of vitamin C 500 mg (continued on next page)

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F 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	9. One tablet of vitamin D3 5000 IU (An international unit (IU) an internationally accepted amount of a substance). LVN 2 stated Resident 200 should also receive one tablet of zinc sulfate 220 mg, one tablet of ferrous sulfate, one tablet of lactobacillus, and one tablet of sodium chloride 1 gm at 9 a.m. but she did not have those medication available in the medication cart. LVN 2 stated she was planning on obtaining those medications later and would return to administer them. During an interview on 1/25/2023 at 9:54 a.m. with LVN 2, LVN 2 stated the nine medications listed above were the only medications to administer to Resident 200 that morning besides the missing zinc sulfate, ferrous sulfate, sodium chloride, and lactobacillus. During an observation on 1/25/2023 at 9:56 a.m., Resident 200 was observed taking all nine medications listed above by mouth with juice. A review of Resident 200's AR, dated 1/25/2023, the AR indicated Resident 200 was admitted to the facility on [DATE] and last readmitted on [DATE] with diagnoses including Type 2 diabetes, dysarthria (difficulty speaking caused by brain damage,) following cerebral infarction (slow or slurred speech due to a stroke), and essential hypertension. A review of Resident 200's Order Summary Report, dated 1/25/2023, the summary report indicated Resident 200 also had the following medications due to be administered at 9 a.m. every day: 1. Clopidogrel 75 mg by mouth one time a day 2. Multivitamin by mouth one time a day A review of Resident 200's physician order for Admelog insulin, dated 9/9/2022, the order indicated 18 units were to be injected subcutaneously twice daily with breakfast and lunch at 7:15 a.m. and 12 p.m., respectively. A review of Resident 200's order for vitamin C, dated 7/29/2022, the order indicated the prescribed dose was 1000 mg by mouth one time a day. A review of Resident 200's physician order for vitamin D3, dated 9/10/2022, the order indicated the prescribed dose was 2000 IU by mouth one time a day. During an interview on 1/25/2023 at 10:04 a.m. with LVN 1, LVN 1 stated metoprolol succinate, tamsulosin, and fluoxetine for Resident 51 have not yet arrived from the pharmacy and have not been administered. LVN 1 stated the medications would now be considered late even if they are administered later today because medication scheduled for a 9 a.m. administration was due one hour before or after the scheduled time to be considered on time (between 8 a.m. and 10 a.m.). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Artesia Palms Care Center	11900 E. Artesia Blvd. Artesia, CA 90701

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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	During an interview on 1/25/2023 at 10:13 a.m. with LVN 2, LVN 2 stated she should have checked to see if all the medications for Resident 200 were available prior to starting his medication administration. LVN 2 stated the ferrous sulfate, lactobacillus, sodium chloride, and zinc sulfate would now be considered late because they are scheduled for 9 a.m. and will be administered after 10 a.m., LVN 2 stated it was important to make sure she has all medications available before beginning the medication administration to reduce the risk the resident may miss those medications entirely because the nurse forgets to go back and administer them later. A review of Resident 51's Medication Administration Record ([MAR] a record of all medication administered to a resident), for the month of 1/2023, the MAR indicated LVN 1 marked Anoro Ellipta, calcium carbonate, and calcitriol as administered in the record for 9 a.m. on 1/25/2023. A review of Resident 257's MAR for the month of 1/2023, the MAR indicated LVN 1 marked risperidone and sodium chloride as administered in the record for 9 a.m. on 1/25/2023. During an interview on 1/25/2023 at 12:04 p.m. with LVN 1, LVN 1 stated metoprolol succinate, fluoxetine and tamsulosin have still not arrived from the pharmacy for Resident 51. LVN 1 stated she administered the Anoro Ellipta late (after 10 a.m.) for Resident 51 because she saw it on the MAR and remembered she did not administer it. LVN 1 stated she failed to administer the calcium carbonate or the calcitriol because she overlooked them. LVN 1 stated she marked the MAR that calcium carbonate and calcitriol were administered to Resident 51 even though they were not because she was nervous. LVN 1 stated there was currently no supply of calcitriol 0.25 mg capsules for Resident 51 available in her medication cart or anywhere else in the facility. LVN 1 stated she failed to administer the sodium chloride and risperidone to Resident 257 even though she also marked the MAR they were administered at 9 a.m. LVN 1 stated there was currently no supply of risperidone for Resident 257 in her medication cart or anywhere else in the facility. LVN 1 stated the failure to administer medications ordered by the physician may cause medical complications resulting in hospitalization or death. LVN 1 stated failure to administer psychiatric medications, including antipsychotics (psychiatric medication which are available on prescription to treat psychosis), could cause residents to experience psychiatric emergencies which could endanger the safety of that resident, other residents, or facility staff. LVN 1 stated documenting the MAR inaccurately in a way that it does not reflect care the resident received may mislead prescribers to make unnecessary dosage changes to medications possibly resulting in further medical complications. During an interview on 1/25/2023 at 12:21 p.m. with LVN 2, LVN 2 stated she administered the ferrous sulfate, zinc sulfate, sodium chloride, and lactobacillus around 11 a.m. LVN 2 stated these were given late as they were due by 10 a.m. LVN 2 stated medications must be given within one hour before or after their prescribed administration time to be considered on time. (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 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	LVN 2 stated she administered the Admelog to Resident 200 late because it was due at 7:15 a.m. but administered closer to 10 a.m. LVN 2 stated the latest it could be given to be considered on time would be 8:15 a.m. LVN 2 stated she administered the wrong dose of vitamin C to Resident 200 as she gave 500 mg instead of 1000 mg. LVN 2 stated she administered the wrong dose of vitamin D3 to Resident 200 as she gave 5000 IU instead of 2000 IU. LVN 2 stated she failed to administer the multivitamin and clopidogrel to Resident 200 because she overlooked them. LVN 2 stated failing to administer clopidogrel could put Resident 200 at risk for a stroke which could lead to hospitalization or death. LVN 2 stated failure to administer insulin on time could lead to medical complications due to poor blood sugar control. LVN 2 stated failure to administer medications, or the correct doses of medications could result in medical complications possibly resulting in hospitalization . During an interview on 1/25/2023 at 3:44 p.m. with the DON, the DON stated the facility just transferred to an electronic medication refill system with their pharmacy. The DON stated the pharmacy was supposed to receive the refill order about three to four days ahead of time automatically based on the day-supply of medication previous dispensed for the residents. The DON stated the pharmacy can usually deliver those refills the next day. The DON stated if the electronic system fails, the nurses are responsible to notify the nurse supervisor or the pharmacy to request a refill for the resident. The DON stated neither he nor his staff conducts any oversight, such as periodic audits, of the pharmacy refill process to ensure it is working correctly but relies on the licensed staff to notify the pharmacy when medications are low to request a refill. The DON stated the facility leadership should implement some sort of oversight process due to residents being found without medications available for which they have active orders. The DON stated failing to administer medication according to the physician's orders may cause medical complications possibly resulting in hospitalization or death. The DON stated he was unaware licensed staff were falsifying entries on the MAR to indicate medications were administered when they were not even available in the facility. The DON stated he would determine which nurses were responsible for the falsified MAR entries and provide them one-on-one counseling and discipline as necessary. The DON stated the MAR must accurately reflect care provided to the residents otherwise it could cause medical providers to make unnecessary dosage changes to medications that could result in poor outcomes for the residents negatively affecting their quality of life. During a review of the facility's policy and procedure (P/P), dated 4/2008 and titled Medication Administration - General Guidelines, the P/P indicated Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so . Medications are administered in accordance with written orders of the attending physician . Medications are administered within 60 minutes of scheduled time (an hour before and an hour after), except before or after meal orders, which are administered based on mealtimes . The individual who administered the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medication reviews the MAR to ensure necessary doses were administered and documented. During a review of the facility's P/P, dated 11/2017 and titled, Medication and Treatment Administration Record, the P/P indicated Medications and treatments shall be administered as prescribed by the physician and shall be recorded by the responsible licensed nurse as the medication and/or treatment is provided. The attending physician shall be notified in the event an order cannot be administered as prescribed. (continued on next page)

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F 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of the facility's P/P revised 11/2017 and titled, Medication Errors, the P/P indicated It is the policy of this facility that medication errors will be reported to the resident, his/her physician and to the resident/resident representative . A medication error is defined as administration to a resident: At the wrong time . at the wrong dose . omission of the prescribed medication (unless refused by the resident) . When first discovered, the medication error shall immediately be reported to the physician for appropriate actions to be taken.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on observation, interview, and record review, the facility failed to ensure residents were free from significant medication errors by failing to administer eight medications according to the physician's order on 1/25/2023 affecting three of six residents observed for medication administration (Residents 51, 200, and 257) [crossed referenced to F759]. The medication errors noted were as follows: 1. Omitted or late administration of metoprolol succinate (a medication used to treat high blood pressure) 50 milligrams ([mg] a unit of measure for mass) for Resident 51. 2. Omitted or late administration of tamsulosin 0.4 mg (a medication used to treat prostate problems) for Resident 51. 3. Omitted or late administration of fluoxetine 10 mg (a medication used to treat mental illness) for Resident 51. 4. Omitted or late administration of Anoro Ellipta (a medication used to treat breathing problems) for Resident 51. 5. Omitted or late administration of calcitriol (a medication used to treat low calcium for patients with bone or kidney disease) 0.25 mg for Resident 51. 6. Omitted or late administration of risperidone (a medication used to treat mental illness) 3 mg for Resident 257. 7. Late administration of Admelog (a type of insulin used to treat high blood sugar) for Resident 200. 8. Omitted or late administration of clopidogrel (a medication used to prevent stroke) 75 mg for Resident 200. The deficient practice of failing to administer medications in accordance with the physician's orders increased the risk that Residents 51, 200, and 257 may have experienced serious medical complications such as stroke or complications related to poor blood sugar or blood pressure control possibly resulting in hospitalization or death. The deficient practice of failing to administer psychiatric medications to Resident 51 and 257 could have resulted in a psychiatric emergency possibly threatening their safety, the safety of other residents, and facility staff. Findings: During a concurrent observation of medication administration and interview with the Licensed Vocational Nurse (LVN 1) on 1/25/2023 at 8:28 a.m., LVN 1 was observed preparing the following medications for Resident 51: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. One tablet of amlodipine (a medication used to treat high blood pressure) 5 mg 2. One multivitamin tablet 3. One tablet of vitamin B1 100 mg (a supplement) 4. Two tablets of vitamin D3 1000 international units ([IU] a unit of dose for vitamins) 5. One tablet of Farxiga (a medication used to treat high blood sugar) 10 mg. 6. One tablet of finasteride (a medication used to treat prostate problems) 5 mg. LVN 1 stated Resident 51 also have orders for metoprolol succinate 50 mg, tamsulosin 0.4 mg, and fluoxetine 10 mg due to be administered at 9 a.m., but they are currently out of stock. LVN 1 stated the pharmacy is supposed to automatically send medication refills so she does not know why they are not here. LVN 1 stated she will follow up with the pharmacy to obtain the missing medications right away. An observation of the pharmacy label on the empty medication bubble pack (a card prepared by the pharmacy containing the individual doses of medications) for metoprolol succinate 50 mg showed it was last refilled for a fourteen-day supply on 12/26/2022. An observation of the pharmacy label on the empty medication bubble pack for fluoxetine 10 mg showed it was last filled for a fourteen day-supply on 12/27/2022. An observation of the pharmacy label on the empty medication bubble pack for tamsulosin 0.4 mg showed it was last filled for a 30 day-supply on 12/20/2022. During an interview on 1/25/2023 at 8:57 a.m., LVN 1 stated the six medications listed above were the only medications to administer to Resident 51 this morning besides the missing metoprolol succinate 50 mg, tamsulosin 0.4 mg, and fluoxetine 10 mg. LVN 1 stated she ordered the missing medications from the pharmacy and will administer them later when they arrive. During an observation on 1/25/2023 at 9 a.m., Resident 51 was observed taking all six medications listed above by mouth with water A review of Resident 51's Admission Record ([AR] a document containing demographic and diagnostic information), dated 1/25/2023, the AR indicated Resident 51 was admitted to the facility on [DATE] and last readmitted [DATE] with diagnoses including essential hypertension (high blood pressure), Type 2 diabetes mellitus (a medical condition characterized by the body's inability to control blood sugar levels), major depressive disorder (a mental illness characterized by changed in mood, lack of energy, social withdrawal, and lack of interest in usually enjoyable activities), and chronic kidney disease (loss in kidney function over time leading to waste and fluid buildup in the blood). A review of Resident 51's Order Summary Report (a list of all currently active medical orders), dated 1/25/2023, indicated Resident 51 also had the following medications due to be administered every day at 9 a.m.: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Anoro Ellipta - inhale one puff by mouth once daily 2. Calcitriol 0.25 mg by mouth once daily. 3. Calcium carbonate 500 mg by mouth three times daily During an observation of medication administration with LVN 1 on 1/25/2023 at 9:03 a.m., LVN 1 was observed preparing the following medications for Resident 257: 1. One tablet of metformin (a medication used to control blood sugar)1000 mg 2. One and one-half tablets of fluvoxamine (a medication used to treat mental illness) 100 mg 3. One tablet of clonazepam (a medication used to treat mental illness) one (1) mg 4. One tablespoon of a fiber supplement (a supplement used to aid bowel movements) mixed in approximately 4 ounces of water. 5. One multivitamin tablet 6. One tablet of sennosides (a laxative used to aid bowel movements) 8.6 mg 7. One tablet of finasteride 5 mg 8. One capsule of tamsulosin 0.4 mg 9. Three and one-half tablets of quetiapine (a medication used to treat mental illness) 100 mg. During an interview on 1/25/2023 at 9:16 a.m., LVN 1 stated the nine medications listed above were the only mediations to administer to Resident 257 this morning. During an observation on 1/25/2023 at 9:21 a.m., Resident 257 was observed taking all nine medications listed above with water. A review of Resident 257's Admission Record, dated 1/25/2023, indicated he was admitted to the facility on [DATE] with diagnoses including Type 2 diabetes mellitus, schizophrenia (a mental illness characterized by hearing and seeing things that are not there), and schizoaffective disorder, bipolar type (a mental illness characterized by hallucinations, delusions, and mood swings between mania and sometimes depression). A review of Resident 257's Order Summary Report, dated 1/25/2023, the report indicated Resident 257 also had the following medications due to be administered every day at 9 a.m.: 1. Sodium Chloride 1 gm by mouth one time a day 2. Risperidone 3 mg by mouth by mouth two times a day (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of medication administration with LVN 2 on 1/25/2023 at 9:33 a.m., LVN 2 was observed preparing 18 units (a measure of dose for insulin) of Admelog for Resident 200. During an observation on 1/25/2023 at 9:38 a.m., LVN 2 was observed administering 18 units of Admelog insulin by subcutaneous (under the skin) injection into Resident 200's left lower abdomen. During an observation of medication administration and concurrent interview with LVN 2 on 1/25/2023 at 9:42 a.m., LVN 2 was observed preparing the following medications for Resident 200: 1. One tablet of Farxiga 10 mg 2. One tablet of icosapent ethyl (a medication used to lower cholesterol) 1 gm 3. One tablet of losartan (a medication used to treat high blood pressure) 25 mg 4. One tablet of magnesium oxide (a supplement) 5. One tablet of metformin 1000 mg 6. One tablet of metoprolol tartrate (a medication used to treat high blood pressure 25 mg 7. One tablet of vitamin B-6 (a supplement) 25 mg 8. One tablet of vitamin C 500 mg 9. One tablet of vitamin D3 5000 IU LVN 2 stated Resident 200 should also receive one tablet of zinc sulfate 220 mg, one tablet of ferrous sulfate, one tablet of lactobacillus, and one tablet of sodium chloride 1 gm at 9 a.m., but she did not have those medication available in the medication cart. LVN 2 stated she was planning on obtaining those medication later and would return to administer them. During an interview on 1/25/2023 at 9:54 a.m. with LVN 2, LVN 2 stated the nines medications listed above were the only medications to administer to Resident 200 this morning besides the missing zinc sulfate, ferrous sulfate, sodium chloride, and lactobacillus. During an observation on 1/25/2023 at 9:56 a.m., Resident 200 was observed taking all nine medications listed above by mouth with juice. A review of Resident 200's Admission Record (AR) dated 1/25/2023, the AR indicated Resident 200 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Type 2 diabetes, dysarthria following cerebral infarction (slow or slurred speech due to a stroke), and essential hypertension. A review of Resident 200's Order Summary Report, dated 1/25/2023, indicated Resident 200 also had the following medications due to be administered at 9 a.m. every day: 1. Clopidogrel 75 mg by mouth one time a day (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Multivitamin by mouth one time a day A review of Resident 200's order for Admelog insulin, dated 9/9/2022, the order indicated 18 units were to be injected subcutaneously twice daily with breakfast and lunch at 7:15 a.m. and 12 p.m., respectively. A review of Resident 200's order for vitamin C, dated 7/29/2022, the order indicated the prescribed dose was 1000 mg by mouth one time a day. A review of Resident 200's order for vitamin D3, dated 9/10/2022, the order indicated the prescribed dose was 2000 IU by mouth one time a day. During an interview on 1/25/2023 at 10:04 a.m. with LVN 1, LVN 1 stated metoprolol succinate, tamsulosin, and fluoxetine for Resident 51 have not yet arrived from the pharmacy and have not been administered. LVN 1 stated the medications would now be considered late even if they are administered later today because for medication scheduled for a 9 a.m. administration, there was a one-hour window before and after to administer for them to be considered on time (between 8 a.m. and 10 a.m.). During an interview on 1/25/2023 at 10:13 a.m. with LVN 2, LVN 2 stated she should have checked to see if all the medications for Resident 200 were available prior to starting his medication administration. LVN 2 stated the ferrous sulfate, lactobacillus, sodium chloride, and zinc sulfate would now be considered late because they are scheduled for 9 a.m. and will be administered after 10 a.m. LVN 2 stated it was important to make sure that she has all medications available before beginning the medication administration to reduce the risk that the resident may miss those medications entirely because the nurse forgets to go back and administer them later. A review of Resident 51's Medication Administration Record ([MAR] a record of all medication administered to a resident), for the month of 1/2023, the MAR indicated LVN 1 marked Anoro Ellipta, calcium carbonate, and calcitriol as administered in the record for 9 a.m. on 1/25/2023. A review of Resident 257's MAR for the month of 1/2023, the MAR indicated LVN 1 marked risperidone and sodium chloride as administered in the record for 9 a.m. on 1/25/2023. During an interview on 1/25/2023 at 12:04 p.m. with LVN 1, LVN 1 stated metoprolol succinate, fluoxetine and tamsulosin have still not arrived from the pharmacy for Resident 51. LVN 1 stated she administered the Anoro Ellipta late (after 10 a.m.) for Resident 51 because she saw it on the MAR and remembered she did not administer it. LVN 1 stated she failed to administer the calcium carbonate or the calcitriol because she overlooked them. LVN 1 stated she marked the MAR for calcium carbonate and calcitriol were administered to Resident 51 even though they were not because she was nervous. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN 1 stated there was currently no supply of calcitriol 0.25 mg capsules for Resident 51 available in her medication cart or anywhere else in the facility. LVN 1 stated she failed to administer the sodium chloride and risperidone to Resident 257 even though she also marked the MAR that they were administered at 9 a. m. LVN 1 stated there was currently no supply of risperidone for Resident 257 in her medication cart or anywhere else in the facility. LVN 1 stated failure to administer medications ordered by the physician may cause medical complications resulting in hospitalization or death. LVN 1 stated failure to administer psychiatric medications, including antipsychotics, could cause residents to experience psychiatric emergencies which could endanger the safety of that resident, other residents, or facility staff. LVN 1 stated documenting the MAR inaccurately in a way that it does not reflect care the resident actually received may mislead prescribers to make unnecessary dosage changes to medications possibly resulting in further medical complications. During an interview on 1/25/2023 at 12:21 p.m. with LVN 2, LVN 2 stated she administered the ferrous sulfate, zinc sulfate, sodium chloride, and lactobacillus around 11 a.m. LVN 2 stated these were given late as they were due by 10 a.m. LVN 2 stated medications must be given within one hour before or after their prescribed administration time to be considered on time. LVN 2 stated she administered the Admelog to Resident 200 late because it was due at 7:15 a.m., but administered close to 10 a.m. LVN 2 stated the latest it could be given to be considered on time would be 8:15 a.m. LVN 2 stated she administered the wrong dose of vitamin C to Resident 200 as she gave 500 mg instead of 1000 mg. LVN 2 stated she administered the wrong dose of vitamin D3 to Resident 200 as she gave 5000 IU instead of 2000 IU. LVN 2 stated she failed to administer the multivitamin and clopidogrel to Resident 200 because she overlooked them. LVN 2 stated that failing to administer clopidogrel could put Resident 200 at risk for a stroke which could lead to hospitalization or death. LVN 2 stated failure to administer insulin on time could lead to medical complications due to poor blood sugar control. LVN 2 stated failure to administer medications, or the correct doses of medications could result in medical complications possibly resulting in hospitalization . During an interview on 1/25/2023 at 3:44 p.m. with the DON, the DON stated the facility just transferred to an electronic medication refill system with their pharmacy. The DON stated the pharmacy was supposed to receive the refill order about three to four days ahead of time automatically based on the day-supply of medication previous dispensed for the residents. The DON stated the pharmacy can usually deliver those refills the next day. The DON stated if the electronic system fails, the nurses are responsible to notify the nurse supervisor or the pharmacy to request a refill for the resident. The DON stated neither he nor his staff conducts any oversight, such as periodic audits, of the pharmacy refill process to ensure it is working correctly but relies on the licensed staff to notify the pharmacy when medications are low to request a refill. The DON stated the facility leadership should implement some sort of oversight process due to residents being found without medications available for which they have active orders. The DON stated failing to administer medication according to the physician's orders may cause medical complications possibly resulting in hospitalization or death. The DON stated he was unaware licensed staff were falsifying entries into the MAR to indicate medications were administered when they were not available in the facility. The DON stated he would determine which nurses were responsible for the falsified MAR entries and provide them one-on-one counseling and discipline as necessary. The DON stated the MAR must accurately reflect care provided to the residents otherwise it could cause medical providers to make unnecessary dosage changes to medications that could result in poor outcomes for the residents negatively affecting their quality of life. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P/P) dated 4/2008 and titled, Medication Administration - General Guidelines, the P/P indicated Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so . Medications are administered in accordance with written orders of the attending physician . Medications are administered within 60 minutes of scheduled time (1 hour before and 1 hour after), expect before or after meal orders, which are administered based on mealtimes . The individual who administered the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medication reviews the MAR to ensure necessary doses were administered and documented. A review of the facility's policy and procedure (P/P) Medication and Treatment Administration Record, dated 11/2017, the P/P indicated Medications and treatments shall be administered as prescribed by the physician and shall be recorded by the responsible licensed nurse as the medication and/or treatment is provided. The attending physician shall be notified in the event an order cannot be administered as prescribed. During a review of the facility's P/P titled, Medication Errors, revised November 2017, indicated It is the policy of this facility that medication errors will be reported to the resident, his/her physician and to the resident/resident representative . A medication error is defined as administration to a resident: At the wrong time . at the wrong dose . omission of the prescribed medication (unless refused by the resident) . When first discovered, the medication error shall immediately be reported to the physician for appropriate actions to be taken.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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. 40994 Based on observation, interview, and record review the facility failed to: 1. Ensure expired medications were removed from the cart and replaced affecting Residents 1, 156, and 170 in three of five inspected medication carts (Palm Terrace East, Palm Terrace Middle, and Palm Terrace West). 2. Ensure opened insulin was labeled with an open date affecting Residents 97, 174, and 242 in one of three inspected medication carts (Palm Terrace West). 3. Ensure medications requiring refrigeration were stored according to the manufacturer's requirements affecting Residents 49, 74, 89, and 174 of two of five inspected medication carts (Palm Terrace Middle and Palm Terrace West). These deficient practices of failing to store or label medications per the manufacturers' requirements increased the risk that Residents 1, 49, 74, 89, 97, 156, 170, 174 and 242 could have received medication that had become ineffective or toxic due to improper storage or labeling possibly leading to health complications resulting in hospitalization or death. Findings: During a concurrent observation and interview on 1/26/2023 at 10:58 a.m. of Palm Terrace East Medication Cart with the Licensed Vocational Nurse 3 (LVN 3), the following medications were found either expired, stored in a manner contrary to their respective manufacturer's requirements, or not labeled with an open date as required by their respective manufacturer's specifications: 1. One glargine insulin (a type of insulin used to treat high blood sugar) pen for Resident 156 was found labeled with an open date of 11/28/2022. According to the manufacturer's product labeling, glargine insulin pens should be used or discarded within 28 days of opening. LVN 3 stated the Resident 156's glargine insulin pen is expired and should have already been removed from the medication cart. LVN 3 stated it was unsafe to administer expired insulin to the resident because it may be ineffective at controlling blood sugar which could possibly lead to poor blood sugar control resulting in other medical complications. LVN 3 stated he would look to see if this resident has a newer supply in the med room or order from the pharmacy if needed. During a concurrent observation and interview on 1/26/2023 at 11:08 a.m. of Palm Terrace Middle Medication Cart with LVN 4, the following medications were found either expired, stored in a manner contrary to their respective manufacturer's requirements, or not labeled with an open date as required by their respective manufacturer's specifications: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. One bottle of latanoprost (a medication used to treat eye problems) eye drops for Resident 1 labeled with an open date of 12/3/2022. According to the manufacturer's product labeling, latanoprost may be stored at room temperature for up to six weeks after opening. 2. One pharmacy bottle containing approximately four ounces (a unit of measure for volume) of gabapentin (a medication used to treat nerve pain) 250 milligrams ([mg] a unit of measure for mass) per milliliter ([ml] a unit of measure for volume) solution for Resident 74 was found labeled with a refrigerate sticker but stored at room temperature. According to the manufacturer's product labeling, gabapentin oral solution should be stored in the refrigerator. LVN 4 stated Resident 1's latanoprost is now expired since it was opened 12/3/2022. LVN stated typically, they discard eye drops 28 days after opening. LVN 4 stated using them beyond this point may cause them to be ineffective or could risk causing an infection due to loss of sterility. LVN 4 stated Resident 74's gabapentin solution should be kept in the refrigerator. LVN stated giving medications that have been stored at the improper temperature to residents could cause them to be ineffective and lead to medical complications. During a concurrent observation and interview on 1/26/2023 at 11:24 a.m. of Palm Terrace [NAME] Medication Cart with LVN 5, the following medications were found either expired, stored in a manner contrary to their respective manufacturer's requirements, or not labeled with an open date as required by their respective manufacturer's specifications: 1. One opened vial of Humulin R (a type of insulin used to control high blood sugar) for Resident 97 was found unlabeled with an open date. According to the manufacturer's product labeling, opened vials of Humulin R should be used or discarded within 31 days from opening. 2. One opened vial of Humulin R for Resident 170 labeled with an open date of 12/15/2022. According to the manufacturer's product labeling, opened vials of Humulin R should be used or discarded within 31 days from opening. 3. One unopened vial of Humulin R for Resident 242 was stored at room temperature and unlabeled with an open date. According to the manufacturer's product labeling, unopened vials of Humulin R should be stored in the refrigerator. Once opened or stored at room temperature, they should be used or discarded within 31 days. 4. One opened Novolog (a type of insulin used to treat high blood sugar) FlexPen for Resident 174 was found unlabeled with an open date. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the manufacturer's product labeling, once opened, Novolog FlexPens should be used or discarded within 28 days. 5. One unopened Victoza (a medication used to treat high blood sugar) Pen for Resident 89 was found stored at room temperature. According to the manufacturer's product labeling, Victoza Pens should be stored in the refrigerator prior to initial use. 6. One unopened Victoza Pen for Resident 174 was found stored at room temperature. According to the manufacturer's product labeling, Victoza Pens should be stored in the refrigerator prior to initial use. 7. One vial of Epogen (a medication used to increase red blood cells) 10,000 Units (a unit of measurement for dosage) per ml for Resident 49 was found stored at room temperature. According to the manufacturer's product labeling, intact vials of Epogen should be stored in the refrigerator. LVN 5 stated the medications listed above are either expired or have been stored or labeled improperly and are not currently safe to administer to residents. LVN 5 stated because of their storage, these medications may not be effective when administered to residents and could cause worsening of their medical conditions. LVN 5 stated she would need to contact the pharmacy to have these medications replaced to ensure they are safe to administer to the residents. A review of the facility's policy and procedure (P/P), Storage of Medications, dated 4/2008, the P/P indicated Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier . Medications requiring 'refrigeration' .are kept in a refrigerator . Outdated . medications . are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 45425 Based on observation, interview and record review, the facility failed to provide the correct amount of ham and pea tortellini for a regular diet during lunch service. This deficient practice had the potential for 61 of 61 residents on a regular diet to receive less than the required amount of protein as indicated on the therapeutic diet menu. Findings: During an observation on 1/24/2023 at 12:35 p.m., Cook 1 (CK 1) was observed using a 4-ounce (oz) ladle when serving ham and pea tortellini for residents on a regular diet. During an interview on 1/24/2023 at 12:35 p.m. with CK 1, CK 1 stated she read the serving of ham and pea tortellini as 1/2 cup for residents on a regular diet. During a review of the facility's menu spreadsheet for lunch, the spreadsheet indicated 1 1/2 cup of ham and pea tortellini should be served to residents on a regular diet. During an interview on 1/24/2023 at 12:35 p.m. with the Assistant Dietary Supervisor (ADS), the ADS stated the menu spreadsheet in the kitchen's binder was not printed correctly and the portions for the regular diet was missing some numbers. During an interview on 1/24/2023 at 1:25 p.m. with the Dietary Supervisor (DS) and the ADS, the DS and ADS both stated the menu should be followed to ensure the appropriate amount of food was served according to the diet. The DS stated if the correct amount was not served, the residents could lose weight and/or be hungry. During a review of the facility's policy and procedure (P/P)revised 10/24/2017 and titled, Nutrition Services for all Residents, the P/P indicated a nutritional program specific to their needs will be implemented.

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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. 45425 Based on observation, interview and record review, the facility failed: 1. To ensure all food items stored in three refrigerators and two freezers in the kitchen were labeled, dated, and stored a closed container. 2. To ensure raw meat was labeled, dated, and stored on the bottom shelf in one of two refrigerators while the cooked meat was stored on the upper top shelf of the refrigerator. These deficient practices placed the residents at risk for foodborne illness. Findings: During an observation on 1/24/2023 at 8:30 a.m., Freezer 1 had the following: 1. Two open, unlabeled, and not dated containers of frozen okra 2. Two open and not dated bags French fries 3. Three bags of collard greens with no date 4. 15 boxes of frozen vegetables with no date During an observation on 1/24/2023 at 8:32 a.m., Freezer 2 had boxes of ice cream, tater tots, corn, sweet potato French fries without dates. Also in Freezer 2, there was an open container of whipped topping with no date. During an observation on 1/24/2023 at 8:34 a.m., Refrigerator 1 had ground ham, sausage, and a tray of juice with no labels or dates. During an observation on 1/24/2023 at 8:36 a.m., Refrigerator 2 had sandwiches with no labels or date and three boxes of frozen pasta with no dates. During an observation on 1/24/2023 at 8:40 a.m., the walk-in refrigerator had: 1. Raw bacon stored above a cooked ham 2. Raw sausage patties undated next to cooked diced turkey 3. Open container of hot dogs undated with no label 4. Bean and cheese burritos undated 5. Defrosting ground beef with no label and undated (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Open container of butter undated 7. Two bags of cheese undated 8. Opened container of cottage cheese undated During an interview on 1/24/2023 at 8:40 a.m. with the Assistant Dietary Supervisor (ADS), the ADS stated when the kitchen staff places the food in the either the freezer or refrigerator, the food should be labeled with the name and date when placed. The ADS stated placing a date on the food allows the kitchen staff to know how long the food has been in the refrigerator. The ADS also stated that food containers should be sealed. The ADS stated food stored in the refrigerator for thawing should be stored on the bottom shelf with the date it was placed in the refrigerator to prevent contamination of already cooked food. During an interview on 1/24/2023 at 9 a.m. with the DS, the DS stated if food was not properly labeled and stored in the refrigerators and freezers, the residents are at risk for foodborne illnesses. During a review of the facility's policy and procedure (P/P) titled, Storing Frozen Foods revised 1/2013, the P/P indicated when the food was removed from the original containers, the food should be a date and a label. During a review of the facility's P/P titled Storing Refrigerated Foods revised 1/2013, the P/P indicated potentially hazardous foods such as meats, should be stored below ready to eat items. The P/P also indicated raw foods should be stored on the bottom shelves. During a review of the facility's P/P titled Food safety for your loved one revised 4/2017, the P/P indicated foods in unmarked or unlabeled containers should be marked with the current dated the food was stored.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on observation, interview, and record review, the facility failed to ensure administration conducted proper oversight over the facility's medication refill process between the months of 11/12/2022 and 1/26/2023 for three of six sampled residents (Residents 51, 200, and 257) (cross-referenced with F755) These deficient practices increased the risk that Residents 51, 200, and 257 may not have received medication according to their physician's orders resulting in medical complications leading to an overall diminished quality of life. Findings: During a concurrent observation of medication administration and interview with the Licensed Vocational Nurse (LVN 1) on 1/25/2023 at 8:28 a.m., LVN 1 was observed preparing the following medications for Resident 51: 1. One tablet of amlodipine (a medication used to treat high blood pressure) 5 milligrams (mg - a unit of measure for mass.) 2. One multivitamin tablet (a supplement) 3. One tablet of vitamin B1 100 mg (a supplement) 4. Two tablets of vitamin D3 (a supplement) international units ([IU] - a unit of dose for vitamins) 5. One tablet of Farxiga (a medication used to treat high blood sugar) 10 mg. 6. One tablet of finasteride (a medication used to treat prostate problems) 5 mg. LVN 1 stated Resident 51 also has orders for metoprolol succinate (a medication used to treat high blood pressure) 50 mg, tamsulosin (a medication used to treat prostate problems) 0.4 mg, and fluoxetine (a medication used to treat mental illness) 10 mg due to be administered at 9 a.m., but they are currently out of stock. LVN stated the pharmacy was supposed to automatically send medication refills so she does not know why they are not here. LVN 1 stated she will follow up with the pharmacy to obtain the missing medications right away. An observation of the pharmacy label on the empty medication bubble pack (a card prepared by the pharmacy containing the individual doses of medications) for metoprolol succinate 50 mg showed it was last refilled for a fourteen day-supply on 12/26/2022. An observation of the pharmacy label on the empty medication bubble pack for fluoxetine 10 mg showed it was last filled for a fourteen day-supply on 12/27/2022. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation of the pharmacy label on the empty medication bubble pack for tamsulosin 0.4 mg showed it was last filled for a 30 day-supply on 12/20/2022. During an interview on 1/25/2023 at 8:57 a.m., LVN 1 stated the six medications listed above were the only medications to administer to Resident 51 this morning besides the missing metoprolol succinate 50 mg, tamsulosin 0.4 mg, and fluoxetine 10 mg. LVN 1 stated she ordered the missing medications from the pharmacy and will administer them later when they arrive. During an observation on 1/25/2023 at 9 a.m., Resident 51 was observed taking all six medications listed above by mouth with water. A review of Resident 51's Admission Record ([AR] a document containing demographic and diagnostic information), dated 1/25/2023, indicated Resident 51 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including essential hypertension (high blood pressure), Type 2 diabetes mellitus (a medical condition characterized by the body's inability to control blood sugar levels), major depressive disorder (a mental illness characterized by changed in mood, lack of energy, social withdrawal, and lack of interest in usually enjoyable activities), and chronic kidney disease (loss in kidney function over time leading to waste and fluid buildup in the blood). A review of Resident 51's Order Summary Report (a list of all currently active medical orders), dated 1/25/2023, indicated Resident 51 also had the following medications due to be administered every day at 9 a.m.: 1. Anoro Ellipta (a medication used to treat breathing problems) for - inhale one puff by mouth once daily 2. Calcitriol (a medication used to treat low calcium for patients with bone or kidney disease) 0.25 mg by mouth once daily. 3. Calcium carbonate (a supplement) 500 mg by mouth three times daily During an observation of medication administration with LVN 1 on 1/25/2023 at 9:03 a.m., LVN 1 was observed preparing the following medications for Resident 257: 1. One tablet of metformin (a medication used to control blood sugar)1000 mg 2. One and one-half tablets of fluvoxamine (a medication used to treat mental illness) 100 mg 3. One tablet of clonazepam (a medication used to treat mental illness) 1 mg 4. One tablespoon of a fiber supplement (a supplement used to aid bowel movements) mixed in approximately 4 ounces of water. 5. One multivitamin tablet (a supplement) 6. One tablet of sennosides (a laxative used to aid bowel movements) 8.6 mg 7. One tablet of finasteride 5 mg (a medication used to treat prostrate problems) (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. One capsule of tamsulosin 0.4 mg 9. Three and one-half tablets of quetiapine (a medication used to treat mental illness) 100 mg. During an interview on 1/25/2023 at 9:16 a.m., LVN 1 stated the nine medications listed above were the only mediations to administer to Resident 257 this morning. During an observation on 1/25/2023 at 9:21 a.m., Resident 257 is observed taking all nine medications listed above with water. A review of Resident 257's Admission Record, dated 1/25/2023, indicated he was admitted to the facility on [DATE] with diagnoses including Type 2 diabetes mellitus, schizophrenia (a mental illness characterized by hearing and seeing things that are not there), and schizoaffective disorder, bipolar type (a mental illness characterized by hallucinations, delusions, and mood swings between mania and sometimes depression). A review of Resident 257's Order Summary Report, dated 1/25/2023, indicated Resident 257 also had the following medications due to be administered every day at 9 a.m. 1. Sodium Chloride (a supplement) 1 gm by mouth one time a day 2. Risperidone (a medication used to treat mental illness) 3 mg by mouth by mouth two times a day. During a review of Resident 51's Medication Administration Record ([MAR] a record of all medication administered to a resident), the MAR for the month of 1/2023, the indicated LVN 1 marked Anoro Ellipta, calcium carbonate, and calcitriol as administered in the record for 9 a.m. on 1/25/2023. During a review of Resident 257's MAR for the month of 1/2023, indicated LVN 1 marked risperidone and sodium chloride as administered in the record for 9 a.m. on 1/25/2023. A review of the pharmacy delivery manifest, dated 12/23/2022, the manifest indicated the pharmacy delivered a 30 day-supply of tamsulosin 0.4 mg for Resident 51 on 12/23/2022 at 2:20 a.m., if administered per the physician's orders, this supply would have been exhausted by 1/22/2023. During a review of the pharmacy delivery manifest, dated 1/25/2023, indicated the next time the pharmacy delivered tamsulosin 0.4 mg for Resident 51 was on 1/25/2023 at 9:13 p.m. A review of the pharmacy delivery manifest, dated 12/27/2022, the manifest indicated the pharmacy delivered a 14 day-supply of metoprolol succinate 50 mg for Resident 51 on 12/27/2022 at 6:37 p.m., if administered per the physician's orders, this supply would have been exhausted by 1/10/2023. During a review of the pharmacy delivery manifest, dated 1/25/2023, the manifest indicated the next time the pharmacy delivered metoprolol succinate 50 mg for Resident 51 was on 1/25/2023 at 9:13 p.m. During a review of the pharmacy delivery manifest, dated 12/29/2022, the manifest indicated the pharmacy delivered a 14-day supply of fluoxetine 10 mg for Resident 51 on 12/29/2022 at 4:07 a.m., if administered per the physician's orders, this supply would have been exhausted by 1/12/2023. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the pharmacy delivery manifest, dated 1/26/2023, indicated the next time the pharmacy delivered fluoxetine 10 mg for Resident 51 was on 1/26/2023 at 2:21 a.m. A review of the pharmacy delivery manifest, dated 11/1/2022, the manifest indicated the pharmacy delivered a 10 day-supply of calcitriol 0.25 mg for Resident 51 on 11/1/2022 at 10:13 p.m., if administered per the physician's orders, this supply would have been exhausted by 11/12/2022. A review of the pharmacy delivery manifest, dated 1/26/2023, the manifest indicated the next time the pharmacy delivered calcitriol 0.25 mg for Resident 51 was on 1/26/2023 at 3:53 a.m. During a review of the pharmacy delivery manifest, dated 12/24/2022, the manifest indicated the pharmacy delivered a 14-day supply or risperidone 3 mg for Resident 257 on 12/24/2022 at 3:34 p.m. If administered per the physician's orders, this supply would have been exhausted by 1/7/2023. A review of the pharmacy delivery manifest, dated 1/26/2023, the manifest indicated the next time the pharmacy delivered risperidone 3 mg for Resident 257 was on 1/26/2023 at 3:53 a.m. During a review of Resident 51's MAR, dated November 2022, the MAR indicated calcitriol 0.25 mg was administered on every day between 11/12/2022 and 11/30/2022 except for 11/17/2022 when it was marked as unavailable. A review of Resident 51's MAR, dated 12/2022, the MAR indicated calcitriol 0.25 mg was administered on every day between 12/1/2022 and 12/31/2022 except for 12/8/2022, 12/30/2022 and 12/31/2022 when it was marked as unavailable. During a review of Resident 51's MAR, for the month of 1/2023, the MAR indicated calcitriol 0.25 mg was administered on every day between 1/1/2023 and 1/25/2023 except for 1/1/2023, 1/11/2023, 1/12/2023, and 1/13/2023 when it was marked as unavailable. During a review of Resident 51's MAR, for the month of 1/2023, the MAR indicated tamsulosin 0.4 mg was marked as administered on 1/22/2023, 1/23/2023, and 1/24/2023 and was marked unavailable on 1/25/2023. A review of Resident 51's MAR, for the month of 1/2023, the MAR indicated metoprolol succinate 50 mg was marked as administered on every day between 1/10/2023 and 1/24/2023. During a review of Resident 51's MAR, for the month of 1/2023, the MAR indicated fluoxetine 10 mg was marked as administered on every day between 1/12/2023 and 1/24/2023 and was marked as unavailable on 1/25/2023. A review of Resident 257's MAR, for the month of 1/2023, the MAR indicated risperidone 3 mg was marked as administered on every day between 9 a.m. on 1/7/2023 and 9 a.m. on 1/25/2023 except for 9 a.m. on 1/10/2023 and 5 p.m. on 1/11/2023 when it was marked as unavailable. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555565	A. Building B. Wing	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Artesia Palms Care Center	11900 E. Artesia Blvd. Artesia, CA 90701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 1/25/2023 at 11:23 a.m. with the Registered Pharmacist (RPH), the RPH confirmed the above dates and days of supply for Resident 51's metoprolol succinate 50 mg, tamsulosin 0.4 mg, calcitriol 0.25 mg and fluoxetine 10 mg were the most recent the pharmacy delivered. The RPH stated there have been no other refills ordered or delivered for those medications between the date of fill on the prescription labels and today. The RPH stated these medications were not delivered or filled for this resident under any other prescription numbers and based on the days of supply delivered, it looks like Resident 51 may have missed several consecutive days of those medications. During an interview on 1/25/2023 at 12:04 p.m. with LVN 1, LVN 1 stated metoprolol succinate, fluoxetine and tamsulosin have still not arrived from the pharmacy for Resident 51. LVN 1 stated she failed to administer the calcium carbonate or the calcitriol because she overlooked them. LVN 1 stated she marked the MAR that calcium carbonate and calcitriol were administered to Resident 51 even though they were not because she was nervous. LVN 1 stated there was currently no supply of calcitriol 0.25 mg capsules for Resident 51 available in her medication cart or anywhere else in the facility. LVN 1 stated she failed to administer the sodium chloride and risperidone to Resident 257 even though she also marked the MAR that they were administered at 9 a.m. LVN 1 stated there was currently no supply of risperidone for Resident 257 in her medication cart or anywhere else in the facility. LVN 1 stated that failure to administer medications ordered by the physician may cause medical complications resulting in hospitalization or death. LVN 1 stated failure to administer psychiatric medications, including antipsychotics, could cause residents to experience psychiatric emergencies which could endanger the safety of that resident, other residents, or facility staff. LVN 1 stated documenting the MAR inaccurately in a way that it does not reflect care the resident actually received may mislead prescribers to make unnecessary dosage changes to medications possibly resulting in further medical complications. During an interview on 1/25/2023 at 3:44 p.m. with the Director of Nursing (DON), the DON stated the facility just transferred to an electronic medication refill system with their pharmacy. The DON stated the pharmacy was supposed to receive the refill order about three to four days ahead of time automatically based on the day-supply of medication previous dispensed for the residents. The DON stated the pharmacy can usually deliver those refills the next day. The DON stated if the electronic system fails, the nurses are responsible to notify the nurse supervisor or the pharmacy to request a refill for the resident. The DON stated neither he nor his staff conducts any oversight, such as periodic audits, of the pharmacy refill process to ensure it is working correctly but relies on the licensed staff to notify the pharmacy when medications are low to request a refill. The DON stated the facility's leadership should implement some sort of oversight process due to residents being found without medications available for which they have active orders. The DON stated that failing to administer medication according to the physician's orders may cause medical complications possibly resulting in hospitalization or death. The DON stated he was unaware licensed staff were falsifying entries into the MAR to indicate medications were administered when they were not even available in the facility. The DON stated he would determine which nurses were responsible for the falsified MAR entries and provide them one-on-one counseling and discipline as necessary. The DON stated the MAR must accurately reflect care provided to the residents otherwise it could cause medical providers to make unnecessary dosage changes to medications that could result in poor outcomes for the residents negatively affecting their quality of life. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Artesia Palms Care Center	11900 E. Artesia Blvd. Artesia, CA 90701

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/30/2023 at 2:15 p.m. with the Administrator (ADM) and DON, the DON stated the facility changed over to an automatic refill process two to three months ago. The DON stated the system was intended to work by the pharmacy actively tracking medication utilization in the MAR and shipping refills before the previously dispensed day supply was completely utilized. The DON stated from the gaps in days of supply noted for Residents 51, 200, 257, the system is not working as intended. The DON stated prior to these findings being brought to his and ADM's attention on 1/25/2023, there was no oversight of this process to make sure it was working as intended. The ADM stated the facility failed to check in on the pharmacy to ensure they were delivering on their part of the agreement which led to gaps in medication supply. The DON stated neither he nor any designee conducted any regular audits of medication availability and instead relied on individual nurses conducting medication administration to communicate any medication availability issues or order refills from the pharmacy directly. The ADM stated moving forward weekly medication availability audits will be conducted by licensed staff when conducting weekly summary reports, the DON will be responsible for conducting oversight of those audits, and the arrangement with the pharmacy will be streamlined to ensure they are delivering medications prior to the current supply being exhausted. During a review of the facility's policy and procedure (P/P) Ordering and Receiving Medications from the Dispensing Pharmacy, dated 4/2008, the P/P indicated Medications and related products are received from the dispensing pharmacy on a timely basis . If not automatically refilled by the pharmacy, repeat medications (refills) are written on a medication order form/ordered by peeling the bottom part of the pharmacy label and placing it in the appropriate area on the order form provided by the pharmacy for that purpose and ordered as follows: Reorder medication five days in advance of need to assure an adequate supply is on hand . The refill order is called in, faxed, or otherwise transmitted to the pharmacy .

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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 - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on observation, interview, and record review, the facility failed to ensure licensed staff did not falsify medication administration record ([MAR] a record of all medications administered to a resident) entries as administered for medications not present in the facility for the months of 11/12/2022 and 1/25/2023 (over two months) for two of six sampled residents (Residents 51 and 257). 1. For Resident 51, the nurses were documenting on the MAR for the month of 1/2023 for Anoro Ellipta, calcium carbonate, and calcitriol as administered for 9 a.m. on 1/25/2023. 2. For Resident 257, the nurses were documenting administered for pantoprazole (medication used to treat heartburn, acid reflux and gastro-esophageal reflux disease [GERD]) not present in the facility between 1/13/2023 and 1/21/2023 (for over 7 days). For risperidone and sodium chloride as administered on the record for 9 a.m. on 1/25/2023. These deficient practice of failing to ensure the medical records accurately reflect care delivered to the resident increased the risk Residents 51 and 257 may not have received their medications as ordered and may have received unnecessary dosage adjustments to their medications possibly resulting in medical complications leading to an overall diminished quality of life. Findings: a. During a concurrent observation of medication administration and interview with the Licensed Vocational Nurse 1 (LVN 1) on 1/25/2023 at 8:28 a.m., LVN 1 was observed preparing the following medications for Resident 51: 1. One tablet of amlodipine (a medication used to treat high blood pressure) 5 milligrams (mg - a unit of measure for mass.) 2. One multivitamin tablet (a supplement) 3. One tablet of vitamin B1 100 mg (a supplement) 4. Two tablets of vitamin D3 (a supplement) international units ([IU] a unit of dose for vitamins) 5. One tablet of Farxiga (a medication used to treat high blood sugar) 10 mg. 6. One tablet of finasteride (a medication used to treat prostate problems) 5 mg. LVN 1 stated Resident 51 also has orders for metoprolol succinate (a medication used to treat high blood pressure) 50 mg, tamsulosin (a medication used to treat prostate problems) 0.4 mg, and fluoxetine (a medication used to treat mental illness) 10 mg due to be administered at 9 a.m., but they are currently out of stock. LVN 1 stated the pharmacy was supposed to automatically send medication refills so she does not know why they are not here. LVN 1 stated she will follow up with the pharmacy to obtain the missing medications right away. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of the pharmacy label on the empty medication bubble pack (a card prepared by the pharmacy containing the individual doses of medications) for metoprolol succinate 50 mg showed it was last refilled for a fourteen day-supply on 12/26/2022. During an observation of the pharmacy label on the empty medication bubble pack for fluoxetine 10 mg showed it was last filled for a fourteen day-supply on 12/27/2022. During an observation of the pharmacy label on the empty medication bubble pack for tamsulosin 0.4 mg showed it was last filled for a 30-day supply on 12/20/2022. During an interview on 1/25/2023 at 8:57 a.m., LVN 1 stated the six medications listed above were the only medications to administer to Resident 51 that morning besides the missing metoprolol succinate 50 mg, tamsulosin 0.4 mg, and fluoxetine 10 mg. LVN 1 stated she ordered the missing medications from the pharmacy and will administer them later when they arrive. During an observation on 1/25/2023 at 9 a.m., Resident 51 was observed taking all six medications listed above by mouth with water. A review of Resident 51's Admission Record ([AR] a document containing demographic and diagnostic information), dated 1/25/2023, the AR indicated Resident 51 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including essential hypertension (high blood pressure), Type 2 diabetes mellitus (a medical condition characterized by the body's inability to control blood sugar levels), major depressive disorder (a mental illness characterized by changed in mood, lack of energy, social withdrawal, and lack of interest in usually enjoyable activities), and chronic kidney disease (loss in kidney function over time leading to waste and fluid buildup in the blood). During a review of Resident 51's Order Summary Report (a list of all currently active medical orders), dated 1/25/2023, the report indicated Resident 51 also had the following medications due to be administered every day at 9 a.m.: 1. Anoro Ellipta (a medication used to treat breathing problems) - inhale one puff by mouth once daily 2. Calcitriol (a medication used to treat low calcium for patients with bone or kidney disease) 0.25 mg by mouth once daily. 3.Calcium carbonate (a supplement) 500 mg by mouth three times daily During an observation of medication administration with LVN 1 on 1/25/2023 at 9:03 a.m., LVN 1 was observed preparing the following medications for Resident 257: 1. One tablet of metformin (a medication used to control blood sugar)1000 mg 2. One and one-half tablets of fluvoxamine (a medication used to treat mental illness) 100 mg 3. One tablet of clonazepam (a medication used to treat mental illness) 1 mg (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. One tablespoon of a fiber supplement (a supplement used to aid bowel movements) mixed in approximately 4 ounces of water. 5. One multivitamin tablet (a supplement) 6. One tablet of sennosides (a laxative used to aid bowel movements) 8.6 mg 7. One tablet of finasteride 5 mg (a medication used to treat prostrate problems) 8. One capsule of tamsulosin 0.4 mg 9. Three and one-half tablets of quetiapine (a medication used to treat mental illness) 100 mg. During an interview on 1/25/2023 at 9:16 a.m., LVN 1 stated the nine medications listed above were the only mediations to administer to Resident 257 that morning. During an observation on 1/25/2023 at 9:21 a.m., Resident 257 was observed taking all nine medications listed above with water. During a review of Resident 257's AR, dated 1/25/2023, the AR indicated the resident was admitted to the facility on [DATE] with diagnoses including Type 2 diabetes mellitus, schizophrenia (a mental illness characterized by hearing and seeing things that are not there), and schizoaffective disorder, bipolar type (a mental illness characterized by hallucinations, delusions, and mood swings between mania and sometimes depression). A review of Resident 257's Order Summary Report, dated 1/25/2023, the report indicated Resident 257 also had the following medications due to be administered every day at 9 a.m.: 1. Sodium Chloride (a supplement) 1 gm by mouth one time a day 2. Risperidone (a medication used to treat mental illness) 3 mg by mouth by mouth two times a day During a review of Resident 51's MAR, for the month of 1/2023, the MAR indicated LVN 1 marked Anoro Ellipta, calcium carbonate, and calcitriol as administered on the record for 9 a.m. on 1/25/2023. A review of Resident 257's MAR for 1/2023, the MAR indicated LVN 1 marked risperidone and sodium chloride as administered on the record for 9 a.m. on 1/25/2023. During a review of the pharmacy delivery manifest, dated 12/23/2022, the manifest indicated the pharmacy delivered a 30 day-supply of tamsulosin 0.4 mg for Resident 51 on 12/23/2022 at 2:20 a.m. If administered per the physician's orders, this supply would have been exhausted by 1/22/2023. During a review of the pharmacy delivery manifest, dated 1/25/2023, the manifest indicated the next time the pharmacy delivered tamsulosin 0.4 mg for Resident 51 was on 1/25/2023 at 9:13 p.m. A review of the pharmacy delivery manifest, dated 12/27/2022,the manifest indicated the pharmacy delivered a 14 day-supply of metoprolol succinate 50 mg for Resident 51 on 12/27/2022 at 6:37 p.m. If administered per the physician's orders, this supply would have been completed by 1/10/2023. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the pharmacy delivery manifest, dated 1/25/2023, the manifest indicated the next time the pharmacy delivered metoprolol succinate 50 mg for Resident 51 was on 1/25/2023 at 9:13 p.m. A review of the pharmacy delivery manifest, dated 12/29/2022, the manifest indicated the pharmacy delivered a 14 day-supply of fluoxetine 10 mg for Resident 51 on 12/29/2022 at 4:07 a.m., if administered per the physician's orders, this supply would have been completed by 1/12/2023. During a review of the pharmacy delivery manifest, dated 1/26/2023, the manifest indicated the next time the pharmacy delivered fluoxetine 10 mg for Resident 51 was on 1/26/2023 at 2:21 a.m. During a review of the pharmacy delivery manifest, dated 11/1/2022, the manifest indicated the pharmacy delivered a 10-day supply of calcitriol 0.25 mg for Resident 51 on 11/1/2022 at 10:13 p.m., if administered per the physician's orders, this supply would have been completed by 11/12/2022. During a review of the pharmacy delivery manifest, dated 1/26/2023, the manifest indicated the next time the pharmacy delivered calcitriol 0.25 mg for Resident 51 was on 1/26/2023 at 3:53 a.m. A review of the pharmacy delivery manifest, dated 12/24/2022, the manifest indicated the pharmacy delivered a 14-day supply of risperidone 3 mg for Resident 257 on 12/24/2022 at 3:34 p.m., if administered per the physician's orders, this supply would have been exhausted by 1/7/2023. During a review of the pharmacy delivery manifest, dated 1/26/2023, the manifest indicated the next time the pharmacy delivered risperidone 3 mg for Resident 257 was on 1/26/2023 at 3:53 a.m. A review of Resident 51's MAR, dated November 2022, the MAR indicated calcitriol 0.25 mg was administered on every day between 11/12/2022 and 11/30/2022 except for 11/17/2022 when it was marked as unavailable. A review of Resident 51's MAR, for the month of 12/2022, the MAR indicated calcitriol 0.25 mg was administered on every day between 12/1/2022 and 12/31/2022 except for 12/8/2022, 12/30/2022 and 12/31/2022 when it was marked as unavailable. During a review of Resident 51's MAR, for the month of 1/2023, the MAR indicated calcitriol 0.25 mg was administered on every day between 1/1/2023 and 1/25/2023 except for 1/1/2023, 1/11/2023, 1/12/2023, and 1/13/2023 when it was marked as unavailable. During a review of Resident 51's MAR, for the month 1/2023, the MAR indicated tamsulosin 0.4 mg was marked as administered on 1/22/2023, 1/23/2023, and 1/24/2023 and was marked unavailable on 1/25/2023. A review of Resident 51's MAR, for the month 1/2023, the MAR indicated: 1. Metoprolol succinate 50 mg was marked as administered on every day between 1/10/2023 and 1/24/2023. 2. Fluoxetine 10 mg was marked as administered on every day between 1/12/2023 and 1/24/2023 and was marked as unavailable on 1/25/2023. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 257's MAR, for the month of 1/2023, the MAR indicated risperidone 3 mg was marked as administered on every day between 9 a.m. on 1/7/2023 and 9 a.m. on 1/25/2023 except for 9 a.m. on 1/10/2023 and 5 p.m. on 1/11/2023 when it was marked as unavailable. During a telephone interview on 1/25/2023 at 11:23 a.m. with the Registered Pharmacist (RPH), the RPH confirmed the above dates and days of supply for Resident 51's metoprolol succinate 50 mg, tamsulosin 0.4 mg, calcitriol 0.25 mg and fluoxetine 10 mg were the most recent the pharmacy delivered. The RPH stated there have been no other refills ordered or delivered for those medications between the date of fill on the prescription labels and today. The RPH stated these medications were not delivered or filled for this resident under any other prescription numbers and based on the days of supply delivered, it looks like Resident 51 may have missed several consecutive days of those medications. During an interview on 1/25/2023 at 12:04 p.m. with LVN 1, LVN 1 stated metoprolol succinate, fluoxetine and tamsulosin have still not arrived from the pharmacy for Resident 51. LVN 1 stated she failed to administer the calcium carbonate or the calcitriol because she overlooked them. LVN 1 stated she marked the MAR that calcium carbonate and calcitriol were administered to Resident 51 even though they were not because she was nervous. LVN 1 stated there was currently no supply of calcitriol 0.25 mg capsules for Resident 51 available in her medication cart or anywhere else in the facility. LVN 1 stated she failed to administer the sodium chloride and risperidone to Resident 257 even though she also marked the MAR that they were administered at 9 a.m. LVN 1 stated there was currently no supply of risperidone for Resident 257 in her medication cart or anywhere else in the facility. LVN 1 stated the failure to administer medications ordered by the physician may cause medical complications resulting in hospitalization or death. LVN 1 stated failure to administer psychiatric medications, including antipsychotics, could cause residents to experience psychiatric emergencies which could endanger the safety of that resident, other residents, or facility staff. LVN 1 stated documenting the MAR inaccurately in a way that it does not reflect care the resident actually received may mislead prescribers to make unnecessary dosage changes to medications possibly resulting in further medical complications. During an interview on 1/25/2023 at 3:44 p.m. with the DON, the DON stated the facility just transferred to an electronic medication refill system with their pharmacy. The DON stated the pharmacy was supposed to receive the refill order about three to four days ahead of time automatically based on the day-supply of medication previous dispensed for the residents. The DON stated the pharmacy can usually deliver those refills the next day. The DON stated if the electronic system fails, the nurses are responsible to notify the nurse supervisor or the pharmacy to request a refill for the resident. The DON stated neither he nor his staff conducts any oversight, such as periodic audits, of the pharmacy refill process to ensure it is working correctly but relies on the licensed staff to notify the pharmacy when medications are low to request a refill. The DON stated the facility's leadership should implement some sort of oversight process due to residents being found without medications available for which they have active orders. The DON stated that failing to administer medication according to the physician's orders may cause medical complications possibly resulting in hospitalization or death. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON stated he was unaware licensed staff were falsifying entries into the MAR to indicate medications were administered when they were not even available in the facility. The DON stated he would determine which nurses were responsible for the falsified MAR entries and provide them one-on-one counseling and discipline as necessary. The DON stated the MAR must accurately reflect care provided to the residents otherwise it could cause medical providers to make unnecessary dosage changes to medications that could result in poor outcomes for the residents negatively affecting their quality of life. 45425 b. During an interview on 1/24/2023 at 10:30 a.m. with Resident 257, Resident 257 stated sometimes the facility runs out of his medications, such as pantoprazole (medication used to treat heartburn, acid reflux and gastro-oesophageal reflux disease (GERD). Resident 257 stated when the facility orders the medications, the medications take a while to be delivered. During a review of Resident 257's Order Summary Report dated 1/25/2023, the report indicated a physician order Pantoprazole sodium tablet delayed response 40 milligram ([mg] unit of measurement), give 40 mg by mouth in the morning related to GERD without esophagitis (inflammation of the esophagus). During a review of the pharmacy delivery manifest, dated 12/30/2022, the manifest indicated the pharmacy delivered a 14-day supply of pantoprazole 40 mg for Resident 257 on 12/20/2022 at 12:36 a.m. If the medication administered per the physician's order, the supply would have been completed by 1/13/2023. During a review of the pharmacy delivery manifest, dated 1/21/2023, the manifest indicated the next time the pharmacy delivered pantoprazole 40 mg for Resident 257 was on 1/21/2023 at 3:50 p.m. During a review of Resident 257's Medication Administration Record (MAR) for the month of 1/2023, the MAR indicated pantoprazole sodium tablet delayed release 40 mg was administered on every day between 1/13/2023 and 1/21/2023 except on 1/18/2023 when it was marked as other. During an interview on 1/30/2023 at 2:15 p.m. with the Director of Nursing (DON), the DON confirmed from the delivery dates, there was no supply of pantoprazole for Resident 257 from 1/14/2023-1/21/2023 (seven days). The DON stated Resident 257 could potentially have negative outcomes due to lack of medication administration of pantoprazole. The DON stated the nurse should have called the pharmacy if the medication was not available. During a review of the facility's policy and procedure (P/P), dated 11/2017 and titled, Medication and Treatment Administration Record, the P/P indicated Medications and treatments shall be administered as prescribed by the physician and shall be recorded by the responsible licensed nurse as the medication and/or treatment is provided. The attending physician shall be notified in the event an order cannot be administered as prescribed . The nurse who administers the medication or treatment is to record his/her initials in the appropriate box on the medication (MAR) and/or treatment administration record(s) (TAR).

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Artesia Palms Care Center	11900 E. Artesia Blvd. Artesia, CA 90701

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45382 Based on observation, interview, and record review, the facility failed to implement and maintain infection control procedures when: a. One staff member did not clean and disinfect shared resident equipment in between and after resident use for three of eight sampled residents (Residents 80, 230, and 206) 1. Restorative Nursing Assistant 3 (RNA 3) did not clean and disinfect a front wheeled walker (FWW, mobility device with two wheels in the front used for support when standing or walking) and wheelchair in between and after resident use for Residents 206, 230, and 80 2 .RNA 3 did not clean and disinfect a cloth gait belt (safety device worn around the waist that can be used to help safely transfer a person from one surface to another) in between use for Resident 206 and Resident 230. b. RNA 3 did not know how to properly clean and disinfect a cloth gait belt after resident use. Findings: During an observation on 1/27/2023 at 9:08 a.m., while in the hallway, RNA 3 was performing a walking exercise with Resident 206. Resident 206 walked down the hallway using a FWW and had a cloth gait belt around the resident's waist. RNA 3 walked behind Resident 206 holding onto the cloth gait belt with one hand and holding onto the wheelchair with the other hand. RNA 3 walked with Resident 206 down the hallway, through the activity room, into another building, and back to the activity room where RNA 3 assisted Resident 206 into a regular chair. RNA 3 removed the cloth gait belt from Resident 206's waist, folded the FWW, placed the FWW in the hallway, and placed the wheelchair in Resident 80's room. RNA 3 did not clean and disinfect the wheelchair, gait belt, and FWW. RNA 3 saw Resident 230 sitting in a wheelchair in the hallway. RNA 3 then proceeded to use the same gait belt and FWW with Resident 230 for walking exercises. After RNA 3 completed walking exercises with Resident 230, RNA 3 removed the cloth gait belt, put the gait belt in her pocket, and placed the FWW against the wall in the RNA room. RNA 3 did not clean and disinfect the cloth gait belt and the FWW after use. During a review of Resident 206's Admission Record (AR), the AR indicated the facility admitted Resident 206 on 8/26/2022 with diagnoses including chronic kidney disease (gradual loss of kidney function), schizoaffective disorder (mental health disorder with characteristics such as hallucinations and mood fluctuations), and muscle weakness. During a review of Resident 80's Admission Record (AR), the AR indicated the resident was originally admitted to the facility on [DATE] and last readmitted to the facility on [DATE]. According to the AR, Resident 80's diagnoses included schizoaffective disorder (mental health disorder with characteristics such as hallucinations and mood fluctuations) and bile duct obstruction (blockage in the tubes that carry bile from the liver to the gallbladder and small intestine). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/27/2023 at 9:08 a.m. with RNA 3, RNA 3 confirmed she did not clean and disinfect the gait belt and FWW after she used them with Resident 206 and before using them again with Resident 230. RNA 3 stated she borrowed the wheelchair from Resident 80 for use with Resident 206 but did not clean and disinfect it after use. RNA 3 stated she should have clean and disinfected all shared equipment in between and after resident use. During an interview on 1/27/2023 at 2:24 p.m. the Infection Preventionist Nurse 1 (IPN 1) stated all shared resident equipment had to be disinfected in between and after each resident use. The IPN stated cloth gait belts should not be used between multiple residents because the only way to properly clean and disinfect cloth gait belts was to launder them after each resident use. The IPN stated shared equipment such as wheelchairs and FWWs must be cleaned and disinfected with bleach wipes in between and after resident use. The IPN stated it was important to clean and disinfect shared equipment properly to prevent the spread of infection. During an observation on 1/27/2023 at 9:08 a.m., while in the hallway, RNA 3 was observed performing walking exercises with Resident 206. Resident 206 walked down the hallway using a FWW and had a cloth gait belt around his waist. RNA 3 walked behind Resident 206 holding onto the cloth gait belt with one hand and holding onto the wheelchair with the other hand. RNA 3 walked with Resident 206 down the hallway, through the activity room, into another building, and back to the activity room where RNA 3 assisted Resident 206 into a regular chair. RNA 3 removed the cloth gait belt, folded the FWW, placed the FWW in the hallway, and placed the wheelchair in Resident 80's room. RNA 3 did not clean and disinfect the wheelchair, gait belt, and FWW. RNA 3 saw Resident 230 sitting in a wheelchair in the hallway. RNA 3 then proceeded to use the same gait belt on Resident 230 for walking exercises. After RNA 3 completed walking exercises with Resident 230, RNA 3 removed the cloth gait belt, put the gait belt in her pocket, and placed the FWW against the wall in the RNA room. RNA 3 did not clean and disinfect the cloth gait belt and FWW after use. During an interview on 1/27/2023 at 9:08 a.m., RNA 3 confirmed she did not clean and disinfect the gait belt after she used it with Resident 206 and before using the gait belt again with Resident 230. RNA 3 stated she did not know how to properly clean and disinfect cloth gait belts. RNA 3 stated she would have used the same gait belt without cleaning and disinfecting in between and after use for all the residents she planned on seeing for the day because she did not know how to properly clean and disinfect the gait belt. During a review of Resident 230's Admission Record (AR), the AR indicated the facility admitted Resident 230 on 5/27/2021 with diagnoses including atrial fibrillation (irregular heart rate), anemia (condition in which there is a lack of healthy red blood cells to carry oxygen to the body's tissues), and depression (mood disorder that causes a persistent feeling of sadness or loss of interest). During an interview on 1/27/2023 at 2:24 p.m. the Infection Preventionist Nurse 1 (IPN 1) stated all shared resident equipment had to be disinfected in between and after each resident use. The IPN stated the only way to properly clean and disinfect cloth gait belts was to launder them after each resident use. The IP stated it was important to clean and disinfect shared equipment properly to prevent the spread of infection. During a follow up interview on 1/31/2023 at 10:05 a.m. IPN 1 stated she had not provided an in service to staff regarding how to properly clean and disinfect cloth gait belts. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedures (P/P), revised 1/10/2019 and titled, Equipment Cleaning and Disinfecting, the P/P indicated all employees were responsible for cleaning up after any procedure or activity and shared patient care equipment will be cleaned and disinfected according to current infection prevention guidelines.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415 Based on interview and record review, the facility failed to document, educate, and provide the benefits and risks of immunization and administration of the pneumonia ([PNA] an infection of the lungs) vaccinations (medication to prevent a particular disease) for three of five sampled residents (Residents 80, 94, and 183). This deficient practice placed these residents at a higher risk of acquiring and transmitting the pneumonia to other residents in the facility. Findings: During a concurrent interview and record review on 1/30/2023 at 9:05 a.m., the Infection Preventionist Nurse 1 (IPN 1) stated residents are supposed to receive the PNA vaccination upon admission if they have not received the PNA vaccination. IPN1 stated if the PNA vaccination status was unknown, the residents' name will be looked up in the California Immunization Registry ([CAIR] a confidential computerized immunization system that provides immunization records for California residents) to see if there was a history the resident have received the PNA vaccination. IPN 1 stated if the resident was not listed in the CAIR, the hospital in which the resident was transferred from will be contacted to obtain the PNA immunization record. IPN1 indicated it was important to keep the resident's immunization record up to date for an overall protection since residents who are older have a higher risk of getting PNA. Concurrent record review with the IPN 1 indicated the following: Resident 80 was admitted to the facility on [DATE] and was supposed to receive the PNA vaccination upon admission. There was no documentation the resident was offered the PNA vaccination nor did the facility follow-up with the resident's previous of PNA vaccination. Resident 94 received the PNA vaccination on 7/13/2013 and another PNA vaccination was due based on the four years look back assessment performed to ensure residents are up to date on their PNA vaccination. There was no documentation the resident was offered the PNA vaccination nor did the facility follow-up. Resident 183 was not eligible to receive the PNA vaccination per documentation as the resident had received the PNA vaccination from a clinic on 5/14/2020. Resident 183 does not recall receiving the PNA vaccination and was self-responsible at that time. Resident 183 have an order to receive the PNA vaccination on 12/6/2022. There was no information regarding Resident 183's PNA vaccination record on CAIR. According to IPN 1, Resident 183 was eligible to receive the PNA vaccination now and should have received a follow-up within that week. Resident 183 also had an active order to receive the PNA vaccination dated 12/6/2022. There was no documentation the resident was offered the PNA vaccination nor did the facility follow-up with the resident. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/30/2023 at 11:51 a.m. with Registered Nurse 2 (RN 2) noted Resident 183 received the PNA vaccination on 12/20/2019. RN 2 stated there was a current order for a PNA vaccination to be administered on 12/6/2022. RN 2 stated there were no notes in the progress notes as to whether Resident 183 received or was administered the PNA vaccination. RN 2 stated if there was an active order, Resident 183 should have been offered the PNA vaccination and indicated there are no other notes regarding the PNA vaccination since 2020. RN 2 stated it was important for the residents to receive the PNA vaccination since the elderly are more prone to getting PNA and other infections. During a review of the facility's policy and procedure (P/P), dated 1/2018 and titled, Infection Prevention & Control Program: Pneumococcal Disease, Precenting Transmission to Residents, the P/P indicated On admission, residents will be evaluated for pneumococcal vaccination needs .Adults aged (greater or equal) [AGE] years of age who have not previously received pneumococcal vaccine or whose previous vaccination history is unknown should receive a dose of PCV13 first, followed by a dose of PPSV23, given 6-12 months after the first dose of the PCV13.

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F 0911 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. 45537 Based on observation, interview and record review, the facility failed to ensure there were only four residents in each room per regulation . The facility had four rooms of the 95 rooms in the facility with five (5) residents residing in the rooms. This failure had the potential for the residents to feel their privacy space were invaded and possibly negatively affect the delivery of each of the resident's care needs and treatment procedures. Findings: During a concurrent observation and interview on 1/30/2023 at 11:26 a.m. with the Administrator (ADM), the ADM showed and confirmed there were three rooms in the facility (Court Area) which had five residents occupied in each room and there was one room in the Terrace area currently occupied by five residents. The ADM stated residents should be accommodated in a room where there are no more than four residents to ensure privacy, homelike environment, and provide a room setting conducive for each of the resident's activities, care needs and treatment procedures. The ADM was asked if there was waiver for the four rooms and he stated, No. During a review of the facility's undated policy and procedure (P/P), the P/P did not indicate the facility have a policy regarding accommodation of five residents in a room.